Not-Reportable Medical Events

The following data was gathered from the Nuclear Material Events Database (NMED) on October 27, 2010 in response to a request from Congressman Markey dated October 26, 2010.

Specifically, the data in this report respond to the Congressman's question "For each of the previous 5 years 2005-2010, please provide the number of times in which the NRC was made aware that the therapeutic and diagnostic medical use of radioactive materials was investigated, questioned, or identified as being at odds with the original medical treatment plan, but was ultimately not designated as a 'medical event'."

The following table lists the number of NMED event records that are designated as not-reportable medical events. These events **are not** medical events per 10CFR 35.3045. Note that an NMED event record may involve more than one patient or procedure. For example, in a review of past procedures, a hospital discovered that prostate brachytherapy seeds were incorrectly positioned in five patients over the last three years. This information is typically included in a single NMED event record. Thus, a single NMED event record may actually include multiple medical events.

Year	Events
2005	39
2006	20
2007	18
2008	13
2009	9
2010*	5
Total	104

NMED Records of Not-Reportable Medical Events (not medical events)

*Note that calendar year 2010 is not yet complete.

The following section contains the NMED event record for each of the 104 events. The manufacturer and model number information for IAEA Category 1-3 sources and devices was redacted.

Full Report

Item Number: 100430

Last Updated: 08/25/2010

Narrative:

The University of Maryland reported that a patient only received approximately 50% of her prescr bed dose during a treatment performed on 3/5/2010 for cervical cancer. The therapy involved five Cs-137 sources with a total activity of (5.07 GBq) 137 mCi. About 20 hours into the 45 hour procedure, the applicator became dislodged following a vigorous coughing episode by the patient. The remainder of the treatment was performed using external beam therapy.

Event Dat	t e: 0	3/05/2010	Discovery Date:	03/09/2010	Report Date	e: 03/10/201	0
Licensee/Reporting Party Inf Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	YS	on: 7-014-01	Reciprocity: Name: City: State: MD	NONE UNIVERSITY OF I BALTIMORE Zip Code: 21201	MARYLAND		
Site of Event: Site Name: BALTIMORE State: MD							
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA NA		Name: City: State: NA	NA NA Zip Code: NA			
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:	Event	N Y Y N			N Y Y Y		
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: PATIENT INTER Corrective Actions Informati Action Number: Corrective MD2	on: Actior	c					
1 NO CORF Patient Information: Patient Number: 1 Patient Informed: U		'E ACTION TAKEN					
Given: Therapeutic Procedure: BRA	ACHY, RVIX	MANUAL AFTERLC	ADER 137 mCi	5069 MBq	Dose:	NR rad	NR Gy
Intended: Therapeutic Procedure: BRA Organ: CEF Radiopharmaceutical: NA Radionuclide: CS-137	ACHY, RVIX	MANUAL AFTERLC Activity:	DADER 137 mCi	5069 MBq	Dose:	NR rad	NR Gy
% Dose Exceeds Prescribed % Dose is Less Than Prescr Effect on Patient:		NA 50					

Source of Radiation:				
MD2				
Source Number: 1				
Source/Radioactive Material:	SEALED SOURCE BRACHYTH	ERAPY Radionuclide of	or Voltage (kVp/MeV): CS-137	
Manufacturer:	NR	Activity:	0.137 Ci	5.069 GBq
Model Number:	NR			
Serial Number:	AGGREGATE			
Device/Associated Equipmen	nt:			
MD2				
Device Number: 1				
Device Name: APPLICA	ATOR	Model Number	nr NR	
Manufacturer: NR		Serial Number	: NR	
References:				
Reference Number: Ent	try Date: Retraction Date:	Coder Initials: Referen	се Туре:	
MD100011 08/2	25/2010	DCH AGREE	MENT STATE EVENT REPORT	

Narrative:

West Valley Imaging reported that a 17-year-old female patient received 0.89 GBq (24 mCi) of Tc-99m for a Miraluma breast study instead of the prescribed 0.65 GBq (17.5 mCi) on 7/21/2010. The standard dose for an adult is 0.93 GBq (25 mCi) of Tc-99m Miraluma. Based on the patient's weight, which was 105 pounds, the pediatric dose was calculated at 0.65 GBq (17.5 mCi). The mammography technician assayed the dose at 0.89 GBq (24 mCi) and injected the patient. The patient received 4.3 cGy (rad) to the large intestine and 0.16 cGy (rad) whole body dose. The root cause was attributed to haste and the mammography technician not recognizing the fact that the patient was a pediatric patient. Corrective actions included better communications and cross-checking correct dosing, especially during pediatric procedures.

Event Dat		Discovery Date:	07/21/2010	Report Date:	07/21/2010
Licensee/Reporting Party Inf					
Agreement State Regulated:		Reciprocity: N			
License Number:	NV-03-12038401		/EST VALLEY IN	IAGING	
NRC Docket Number:	NA	,	ENDERSON		
NRC Program Code:	NA	State: NV Z	ip Code: 89146		
Responsible NRC Region:	4				
Site of Event:					
Site Name: HENDERSON					
State: NV					
Additional Involved Party:					
License Number:	NA	Name: N	A		
NRC Docket Number:	NA	City: N			
NRC Program Code:	NA	State: NA Z			
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal Occ	urrence.	N	
Agreement State Reportable		Investigation:		Y	
Advise Advisering Act Material:	Y	NMED Record	Completo	Y	
Consultant Hired:	N		by Region/State:		
Consultant Filled.	IN	Event Closed	by Region/State.	IN .	
Event Type:					
MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
Cause: COMMUNICATI	ON PROBLEM				
Corrective Actions Information	on:				
Action Number: Corrective	Action:				
MD2					
1 PROCEDI	JRE MODIFIED				
Patient Information:					
Patient Number: 1					
Patient Informed: N	Date Informed:				
Fallent morned. N	Date momen.				
Given:					
Diagnostic Study: MIR	ALUMA SCAN (BREAST I	MAGING)			
Radiopharmaceutical: SES	TAMIBI/CARDIOLITE				
Radionuclide: TC-99M	Activity:	24 mCi	888 MBq		
Intended:					
Diagnostic Study: MIR	ALUMA SCAN (BREAST I	MAGING)			
Radiopharmaceutical: SES	TAMIBI/CARDIOLITE				
Radionuclide: TC-99M	Activity:	17.5 mCi	647.5 MBq		
% Dose Exceeds Prescribed	: 37.14				
10 DUSE EXCEEDS FIESCIDED	. 57.14				

% Dose is Less Than Prescribed: NA

Source of Radiation:				
MD2				
Source Number:	1			
Source/Radioactive Ma	aterial: UNSE	EALED SOURCE RADIC	PHARM F	Radionuclide or Voltage (kVp/MeV): TC-99M
Manufacturer:	CARE	DINAL HEALTH	A	Activity: 0.024 Ci 0.888 GBq
Model Number:	NA			
Serial Number:	NA			
References:				
Reference Number:	Entry Date	Retraction Date:	Coder Initials	s: Reference Type:
EN46117	07/28/2010)	DCH	EVENT NOTIFICATION REPORTED FROM AN AGREEMENT STATE
NV100011	07/28/2010)	DCH	AGREEMENT STATE EVENT REPORT
LTR101018	10/21/2010)	DCH	AGREEMENT STATE LETTER

Effect on Patient: Source of Radiation:

Narrative:

Walla Walla Clinic reported that a patient scheduled to receive 1.11 GBq (30 mCi) of Tc-99m Myoview for a cardiac scan was mistakenly administered 1 GBq (27.1 mCi) of Tc-99m Medronate for a bone scan on 6/8/2010. The mistake was discovered shortly after administration when the technician noticed that the name on the dose did not match that of the patient. The bone scan patient and the cardiac patient had very similar sounding last names, which contr buted to the error. The patient was notified of the error when he returned for his cardiac scan. The bone scan patient was sent home without being administered Tc-99m.

The bone scan patient was ser	t home without being adn	ninistered Tc-99	m.		
Event Date:	06/08/2010	iscovery Date:	06/08/2010	Report Date:	06/09/2010
Licensee/Reporting Party InformAgreement State Regulated:YSLicense Number:WNRC Docket Number:N/NRC Program Code:N/Responsible NRC Region:4	S A-WN-M023 A	City:	NONE WALLA WALLA C WALLA WALLA Zip Code: 99362	LINIC	
Site of Event: Site Name: WALLA WALLA State: WA					
Additional Involved Party:License Number:N/NRC Docket Number:N/NRC Program Code:N/Responsible NRC Region:N/	A A	Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Ev Atomic Energy Act Material: Consultant Hired:	N ent: Y Y N			N N Y N	
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR Corrective Actions Information: Action Number: Corrective Action MD2 1 NOT REPOR	tion:				
Patient Information:Patient Number:1Patient Informed:YGiven:BONE	Date Informed: 06/08	/2010			
Radiopharmaceutical: MEDR Radionuclide: TC-99M	DNATE Activity:	27.1 mCi	1002.7 MBq		
Radiopharmaceutical: MYOVI					
Radionuclide: TC-99M % Dose Exceeds Prescribed: % Dose is Less Than Prescribe	Activity: NA d: NA	30 mCi	1110 MBq		

5

MD2								
Source Number:	1							
Source/Radioactive Ma	aterial:	UNSEAL	ED SOURCE RADIC	PHARM	Radi	onuclide or Voltage (kV	p/MeV): TC-99M	
Manufacturer:		NR			Activ	vity:	0.0271 Ci	1.0027 GBq
Model Number:		NA						
Serial Number:		NA						
References:								
Reference Number:	Entry	/ Date:	Retraction Date:	Coder Initia	als:	Reference Type:		
EN45996	06/15	5/2010		DCH		EVENT NOTIFICATIO AGREEMENT STATE		ROM AN
WA100041	06/15	5/2010		DCH		AGREEMENT STATE	EVENT REPORT	

Narrative:

Memorial Regional Hospital reported that a patient was administered 555 MBq (15 mCi) of Xe-133 on 3/29/2010, instead of the prescribed 370 MBq (10 mCi). It was determined that the nuclear medicine technician had not followed procedures. Neither the patient nor the patient's doctor have been informed of the incident. Corrective actions included requiring the involved technician review and follow established procedures.

procedures.					
Event Da	ite: 03/29/2010	Discovery Date:	03/30/2010	Report Date:	03/30/2010
Licensee/Reporting Party In	formation:				
Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:		City:	NONE MEMORIAL REGI HOLLYWOOD Zip Code: 33021	ONAL HOSPITAL	
Site of Event: Site Name: HOLLYWOOD State: FL					
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	City:	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:		Abnormal Oc Investigation NMED Reco Event Closed	:	N Y Y Y	
Corrective Actions Informati Action Number: Corrective MD2			OURE USED		
Patient Information: Patient Number: 1 Patient Informed: N	Date Informed:				
Given: Diagnostic Study: LUN	NG VENTILATION				
Radiopharmaceutical: NA Radionuclide: XE-133	Activity:	15 mCi	555 MBq		
Intended: Diagnostic Study: LUN	NG VENTILATION				
Radiopharmaceutical: NA Radionuclide: XE-133	Activity:	10 mCi	370 MBq		
% Dose Exceeds Prescribed % Dose is Less Than Presc Effect on Patient: Source of Radiation: MD2					

Source Number:	1					
Source/Radioactive Ma	terial: UNSEAL	ED SOURCE GAS	Rad	lionuclide or Voltage (kVp/MeV): XE-133	
Manufacturer:	NR		Acti	vity:	0.015 Ci	0.555 GBq
Model Number:	NA					
Serial Number:	NA					
eferences:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
FL10-041	05/13/2010		DCH	AGREEMENT STA	TE EVENT REPORT	

Narrative:

The University of Alabama reported two diagnostic medical events that occurred on 1/6/2010, and were caused by the chemical breakdown of the radiopharmaceuticals. One patient received 0.23 GBq (6.19 mCi) of In-111 Octreotide IV and the other patient received 0.24 GBq (6.45 mCi) of In-111 Octreotide IV. Imaging took place four hours and 24 hours post injection. An altered biodistribution was noted in the heart, blood pool, and bone marrow. The liver appeared more intense than the spleen. It was determined that some of the In-111 Octreotide became unbound indium chloride prior to patient injection. On 1/7/2010, Covidian made an urgent drug recall for the lot number that the doses had come from. Dose estimates by the University determined that the maximum effective dose to either patient was 4.66 cSv (rem) and the maximum organ dose to the red marrow was 24 cGy (rad).

Event Dat	t e: 01	1/06/2010 Dis	covery Date:	01/07/2010	Report Date:	01/07/2010
Licensee/Reporting Party Inf	ormatio	on:				
Agreement State Regulated:	YS		Reciprocity:	NONE		
License Number:	AL-026	66	Name:	UNIVERSITY OF A	LABAMA	
NRC Docket Number:	NA		City:	BIRMINGHAM		
NRC Program Code:	NA		State: AL	Zip Code: 35294		
Responsible NRC Region:	1					
Site of Event:						
Site Name: BIRMINGHAM						
State: AL						
Additional Involved Party:						
License Number:	NR		Name:	COVIDIAN		
NRC Docket Number:	NR		City:	NR		
NRC Program Code:	NR		State: NR	Zip Code: NR		
Responsible NRC Region:	NR					
Other Information:						
NRC Reportable Event:		Ν	Abnormal C	occurrence:	Ν	
Agreement State Reportable	Event:	Y	Investigatio	n:	Y	
Atomic Energy Act Material:		Y	NMED Rec	ord Complete:	Y	
Consultant Hired:		Ν	Event Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: NOT REPORTED

Corrective Actions Information:

Action Number: Corrective Action: MD2 1 NOT REPORTED

Patient Informed: Y	Date I	nformed:	01/07/2010					
	Dato							
Given:								
Diagnostic Study:	LIVER							
Radiopharmaceutical:	INDIUM CHLOR	IDE						
Radionuclide: IN-111		Activity:	6.1	9 mCi	229.	03 MBq		
Intended:								
Diagnostic Study:	SPLEEN SCAN							
Radiopharmaceutical:	OCTREOTIDE							
Radionuclide: IN-111		Activity:	6.1	9 mCi	229.	03 MBq		
% Dose Exceeds Press	ribed: NA							
% Dose is Less Than P	rescribed: NA							
Effect on Patient:								
Patient Number: 2			107/00/0					
Patient Informed: Y	Date I	mormed:	01/07/2010					
Given:								
Diagnostic Study:	LIVER							
Radiopharmaceutical:	INDIUM CHLOR	IDE						
Radionuclide: IN-111		Activity:	6.4	5 mCi	238.	65 MBq		
		-						
Intended:								
Diagnostic Study:	SPLEEN SCAN							
Radiopharmaceutical:	OCTREOTIDE							
Radionuclide: IN-111		Activity:	6.4	5 mCi	238.	65 MBq		
% Dose Exceeds Preso	ribed: NA							
% Dose is Less Than P								
Effect on Patient:								
ource of Radiation:								
1D2								
Source Number:	1							
Source/Radioactive Ma	terial: UNSEALE	ED SOURC	E RADIOP	HARM	Radio	nuclide or Voltage	(kVp/MeV): IN-111	
Manufacturer:	NR				Activit	ty:	0.00619 Ci	0.22903 0
Model Number:	NA							
Serial Number:	NA							
Source Number:	2				_			
Source/Radioactive Ma		ED SOURC	E RADIOP				(kVp/MeV): IN-111	
Manufacturer:	NR				Activit	ty:	0.00645 Ci	0.23865 0
Model Number:	NA							
Serial Number:	NA							
eywords:								
REVISED BYPRODUC	I MATERIAL DE	FINITION						
	Entry Date:	Retractio	n Date [.]	Coder Initia	ls:	Reference Type:		
Reference Number:								

Narrative:

Lake Norman Regional Medical Center (LNRMC) reported that a patient was implanted with 41 I-125 brachytherapy seeds using a Mick applicator on 11/19/2009. LNRMC initially stated that all 41 seeds were implanted into the patient's perineal soft tissue, inferior to the prostate gland. Each seed contained an activity of 11.47 MBq (0.31 mCi), with a total activity of 470.27 MBq (12.71 mCi). The patient was prescribed a dose of 14,400 cGy (rad) to the prostate gland. The D90 dose to the prostate was initially calculated to be 102.24 cGy (rad) or 0.71% of the prescribed dose. They stated that the patient may experience possible perineal soft tissue fibrosis due to the incident. The patient and referring physicians were notified of the incident. After further evaluation, the North Carolina Department of Health determined that the incident did not meet the criteria for a medical event. It was determined that the seeds had been implanted on the isoline. It was stated that the seeds could have been placed in better locations. However, 39 of the 41 seeds were placed within the prescribed area (within a few mm of the isoline). The cause was determined to be poor image quality of the prostate during ultrasound and difficult visualization of needle placement. Corrective actions included discontinuation of the procedure if the locations of the needles are not known with relative certainty.

Event Da	te: 1	1/19/2009	Discovery	Date:	12/29/2009	Report Date:	12/29/2009					
Licensee/Reporting Party In	Licensee/Reporting Party Information:											
Agreement State Regulated	: YS		Recipr	ocity:	NONE							
License Number:	NC-04	49-0527-3	Name:		LAKE NORMAN R	EGIONAL MEDICA	AL CENTER					
NRC Docket Number:	NA		City:		MOORESVILLE							
NRC Program Code:	NA		State:	NC	Zip Code: 28117							
Responsible NRC Region:	1											
Site of Event:												
Site Name: MOORESVILLE	Ξ											
State: NC												
Additional Involved Party:												
License Number:	NA		Name:		NA							
NRC Docket Number:	NA		City:		NA							
NRC Program Code:	NA		State:	NA	Zip Code: NA							
Responsible NRC Region:	NA											
Other Information:												
NRC Reportable Event:		Ν	Abnori	nal O	ccurrence:	Ν						
Agreement State Reportable	e Event:	Y	Investi	gatior	1:	Υ						
Atomic Energy Act Material:		Y	NMED	Reco	ord Complete:	Y						
Consultant Hired:		Ν	Event	Close	d by Region/State:	Y						

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2 1 PROCEDURE MODIFIED

Patient Number: 1							
Patient Informed: Y	Date	Informed:					
Given:							
Therapeutic Procedu	re: BRACHY, MAN	IUAL IMPLANT					
Organ:	PERINEUM						
Radiopharmaceutical	: NA						
Radionuclide: I-125	i	Activity:	12.71 mCi	470.27 MBq	Dose:	NR rad	NR Gy
Intended:							
Therapeutic Procedu	re: BRACHY, MAN	IUAL IMPLANT					
Organ:	PROSTATE						
Radiopharmaceutical	: NA						
Radionuclide: I-125	i	Activity:	12.71 mCi	470.27 MBq	Dose:	14400 rad	144 Gy
% Dose Exceeds Pre	scribed: NA						
% Dose is Less Than							
Effect on Patient:							
	A						
Patient Informed: Y		Informed:					
Given:							
Therapeutic Procedu		IUAL IMPLANT					
Organ:	PERINEUM						
Radiopharmaceutical		A - 11 - 11 - 1	10.74	470.07 MD	Deres		
Radionuclide: I-125)	Activity:	12.71 mCi	470.27 MBq	Dose:	NR rad	NR Gy
Intended:							
A therapeutic procedu	ure/diagnostic stud	lv was not intende	d.				
		· · · · · · · · · · · · · · · · · · ·					
% Dose Exceeds Pre	scribed: NF)					
% Dose is Less Than							
Effect on Patient:		L Contraction of the second seco					
Source of Radiation:							
MD2							
Source Number:	1						
Source/Radioactive N	Aaterial: SEALED	SOURCE BRACH	IYTHERAPY	Radionuclide or	· Voltage (k	(Vp/MeV): I-125	
Manufacturer:	NR			Activity:	Ű,	0.01271 Ci	0.47027 GBq
Model Number:	NR						
Serial Number:	AGGRE	GATE					
Device/Associated Eq	uipment [.]						
MD2	a.p.110110						
Device Number: 1							
	APPLICATOR			Model Number:		NR	
	AICK RADIO-NUC	IFAR		Serial Number:		NR	
References:	-	_			_		
Reference Number:	Entry Date:	Retraction Dat					
EN45595	01/04/2010		DCH		IOTIFICAT	ION REPORTED F	ROM AN
NC090063	03/30/2010		DCH			LE LE EVENT REPOR	т
LTR100818	08/24/2010		DCH	NRC LET			-
NC090063A	08/24/2010		DCH			TE EVENT REPOR	т
NOULUUNA	00/24/2010		DOIT	AUNELI			•

Narrative:

Grandview Hospital reported a problem with a nuclear medicine scan on 12/11/2009. The supplier, Medi-Physics, was contacted and advised that the Tc-99m myoview dose revealed a thyroid uptake, but no cardiac uptake, in a patient they injected. Medi-Physics stated that they prepared a 30-ml kit of myoview on 12/11/2009 and the radiochemical purity was determined to be 91%. Medi-Physics confirmed with the Pennsylvania Bureau of Radiation Protection (BRP) that they dispensed 50 doses from the vial of myoview in question. Medi-Physics believes that 13 of those doses were administered to patients in Pennsylvania and New Jersey. Those doses were believed to contain between 296 and 370 MBq (8 and 10 mCi) of Tc-99m. They assured BRP that they have contacted all recipients and explained the problem. They repeated the quality check on the supply of myoview in the vial and determined that the tag was less than 1%. Medi-Physics is investigating the problem and will send the vial to the United Kingdom for chemical analysis once it is no longer radioactive. The BRP has been in contact with all parties involved and will continue to investigate the incident. This incident was retracted on 2/23/2010, based on the fact that the patient's dose was below reportable criteria. BRP is tracking the incident as number PA090035.

Event Da	te: 1	2/11/2009	Disc	covery Date:	12/11/2009	Report Date:	12/11/2009
Licensee/Reporting Party In	format	ion:					
Agreement State Regulated:	YS			Reciprocity	NONE		
License Number:	PA-02	220		Name:	GRANDVIEW HO	SPITAL	
NRC Docket Number:	NA			City:	SELLERSVILLE		
NRC Program Code:	NA			State: PA	Zip Code: NR		
Responsible NRC Region:	1						
Site of Event:							
Site Name: SELLERSVILLE	Ξ						
State: PA							
Additional Involved Party:							
License Number:	PA-0	515		Name:	MEDI-PHYSICS		
NRC Docket Number:	NA			City:	NR		
NRC Program Code:	NA			State: PA	Zip Code: NR		
Responsible NRC Region:	1						
Other Information:							
NRC Reportable Event:		Ν		Abnormal C	Occurrence:	Ν	
Agreement State Reportable	Event	Y		Investigatio	n:	Y	
Atomic Energy Act Material:		Y		NMED Rec	ord Complete:	Y	
Consultant Hired:		Ν		Event Close	ed by Region/State:	Ν	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2

Cause: NOT REPORTED

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Informed: U	Date	e Informed:				
Given:						
Diagnostic Study:	THYROID IMA	GING				
Radiopharmaceutical:	SPERT/PERT	(PERTECHNETATE	E-TCO4			
Radionuclide: TC-99	M	Activity:	10 mCi	370 MBq		
Intended:						
Diagnostic Study:	CARDIAC SCA	AN				
Radiopharmaceutical:	MYOVIEW					
% Dose Exceeds Pres	scribed: NA	4				
% Doop is Loop Than I	Droporihod: N/	^				
% Dose is Less Than I Effect on Patient	Prescribed: NA	4				
% Dose is Less Than I Effect on Patient: Source of Radiation:	Prescribed: NA	Ą				
Effect on Patient: Source of Radiation:	Prescribed: NA	A				
Effect on Patient: ource of Radiation:	Prescribed: NA	4				
Effect on Patient: cource of Radiation: ID2	1		IOPHARM Ra	dionuclide or Voltage	(kVp/MeV): TC-99M	
Effect on Patient: cource of Radiation: ID2 Source Number:	1			idionuclide or Voltage tivity:	(kVp/MeV): TC-99M 0.01 Ci	0.37 GB
Effect on Patient: cource of Radiation: MD2 Source Number: Source/Radioactive Materia	1 aterial: UNSEAI			•	、 、 、 <i>、</i>	0.37 GBc
Effect on Patient: Source of Radiation: MD2 Source Number: Source/Radioactive Manufacturer:	1 aterial: UNSEAI NR			•	、 、 、 <i>、</i>	0.37 GBd
Effect on Patient: Source of Radiation: MD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number:	1 aterial: UNSEAI NR NA			•	、 、 、 <i>、</i>	0.37 GB
Effect on Patient: Source of Radiation: MD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number:	1 aterial: UNSEAI NR NA		Ac	tivity:	、 、 、 <i>、</i>	0.37 GB
Effect on Patient: Source of Radiation: MD2 Source Number: Source/Radioactive Manufacturer: Manufacturer: Model Number: Serial Number: References:	1 laterial: UNSEAI NR NA NA	LED SOURCE RAD	Ac	tivity: Reference Type:	0.01 Ci	

Last Updated: 09/16/2009

Narrative:

Heart Clinics Northwest reported that a patient prescribed 925 MBq (25 mCi) of Tc-99m Pertechnetate was administered a dose of 296 MBq (8 mCi) of Tc-99m Sestam bi on 8/24/2009 that was prescribed for another patient. The patient and physician were notified of the mistake. The whole body dose was calculated to be 0.133 cSv (rem) and the organ dose to the large intestine was 2.56 cSv (rem). This event occurred because the technologist failed to double-check his work while processing two patients. Corrective actions included counseling the technologist on the need for strict adherence to procedures.

technologist on the need for	strict adherence to pro	ocedures.			
Event Dat	te: 08/24/2009	Discovery Date:	08/24/2009	Report Date:	08/25/2009
Licensee/Reporting Party Inf	ormation:				
Agreement State Regulated:	NO	Reciprocity:	NONE		
License Number:	46-27704-01	Name:	HEART CLINICS	NORTHWEST	
NRC Docket Number:	03035760	City:	SPOKANE		
NRC Program Code:	02201	State: WA	Zip Code: 99204		
Responsible NRC Region:	4				
Site of Event: Site Name: COEUR D'ALEN State: ID	ΙE				
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal C	ccurrence:	Ν	
Agreement State Reportable	Event: N	Investigation	n:	Ν	
Atomic Energy Act Material:	Y		ord Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State:	Ν	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROF	۲				
Corrective Actions Informati Action Number: Corrective					
	NEL RECEIVED ADDI	FIONAL TRAINING			
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed	08/24/2009			

Patient Number: 1				
Patient Informed: Y	Da	ate Informed: 08/2	4/2009	
Given:				
Given:				
Diagnostic Study:	MYOCARDIA	AL PERFUSION		
Radiopharmaceutical:	SESTAMIBI/	CARDIOLITE		
•			o o'	000 110
Radionuclide: TC-99	M	Activity:	8 mCi	296 MBq
Intended:				
Diagnostic Study:	GATED BLO			
Diagnostie Otady.	OATED DEO	OD T OOL		
Radiopharmaceutical:	SPERT/PER	T (PERTECHNET	ATE-TCO4	
% Dose Exceeds Prese	cribed: I	NA		
% Dose is Less Than F	Prescribed I	NA		

Effect on Patient:

MD2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rad	dionuclide or Voltage (kVp/	MeV): TC-99M	l
Manufacturer:	NR		Acti	vity:	0.008 Ci	0.296 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
EN45293	08/31/2009		DCH	EVENT NOTIFICATION		
ML092570755	09/16/2009		RLS	LICENSEE REPORT		

Narrative:

G.E. Healthcare reported sending two mislabeled Tc-99m unit doses to Ochsner on 7/9/2009. Ochsner ordered two 0.74 GBq (20 mCi) Tc-99m MDP doses and two patients were injected. After viewing the images, it was determined that the unit doses were mislabeled. An investigation of G.E. Healthcare was performed. A preliminary cause was determined to be a mix up of MDP cold vial with DTPA vial as they closely resemble each other with the same vial configuration and same color label. Contributing factors leading to the incident were a shortage in Tc-99m, late arrival of generators, increased number of kits to prepare, and a pharmacist working alone. Corrective actions involved reviewing procedures and discontinuing manual changes of inventory dispensed on prescription labels. The State of Louisiana is tracking the incident as number LA090017.

Event Dat	te: 07/09/2009	Discovery Date:	07/09/2009	Report Date:	08/25/2009
Licensee/Reporting Party Inf	formation:				
Agreement State Regulated:	YS	Reciprocity:	NONE		
License Number:	LA-5470-L01	Name:	G.E. HEALTHCARE	Ξ	
NRC Docket Number:	NA	City:	NEW ORLEANS		
NRC Program Code:	NA	State: LA	Zip Code: NR		
Responsible NRC Region:	4				
Site of Event:					
Site Name: NEW ORLEANS	S				
State: LA					
Additional Involved Party:					
License Number:	NR	Name:	OCHSNER		
NRC Docket Number:	NR	City:	NR		
NRC Program Code:	NR	State: NR	Zip Code: NR		
Responsible NRC Region:	NR				
Other Information:					
NRC Reportable Event:	Ν	Abnormal C	ccurrence:	N	
Agreement State Reportable	Event: Y	Investigation	n:	Y	
Atomic Energy Act Material:	Y	NMED Reco	ord Complete:	Y	
Consultant Hired:	Ν	Event Close	ed by Region/State:	N	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2 1 PROCEDURE MODIFIED

Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: REN	NAL BLOOD FLOW				
Radiopharmaceutical: DTF Radionuclide: TC-99M	PA (DIETHYLTRIAMINE-PENTAA Activity:		740 MBq		
Intended: Diagnostic Study: BON	NE SCAN				
Radiopharmaceutical: MDI	P/MEDRONATE/OSTEOLITE				
% Dose Exceeds Prescribed % Dose is Less Than Prescr Effect on Patient: Patient Number: 2 Patient Informed: U					
Given:	VAL BLOOD FLOW				
Radiopharmaceutical: DTF Radionuclide: TC-99M	PA (DIETHYLTRIAMINE-PENTAA Activity:		740 MBq		
Intended: Diagnostic Study: BON	NE SCAN				
Radiopharmaceutical: MDI	P/MEDRONATE/OSTEOLITE				
% Dose Exceeds Prescribed % Dose is Less Than Prescr Effect on Patient: Source of Radiation:					
MD2 Source Number: 1 Source/Radioactive Material Manufacturer: Model Number: Serial Number:	: UNSEALED SOURCE RADIO NR NA NA	PHARM Radii Activ	onuclide or Voltage (kVp/MeV ty: 0		.74 GBq
Source Number: 2 Source/Radioactive Material Manufacturer: Model Number: Serial Number:	: UNSEALED SOURCE RADIO NR NA NA	PHARM Radio Activ	onuclide or Voltage (kVp/MeV ity: 0		.74 GBq
	try Date: Retraction Date: /31/2009	Coder Initials: DCH	Reference Type: EVENT NOTIFICATION REF AGREEMENT STATE	PORTED FROM AN	

Narrative:

Lehigh Valley Hospital reported that a patient received a gamma knife treatment to the wrong side of the brain (right side neuralgia). The patient's treatment was halted at 47.40 minutes into the prescribed 55.63 minutes. The prescribed dose to the intended site (left side neuralgia) was 4,250 cGy (rad) to the 50% isodose line. The patient actually received 3,450 cGy (rad) to the 50% isodose line of the unintended site. It was determined that the written directive was generated for treatment of the wrong site. When the neurosurgeon noticed that they were not treating the correct site, treatment was stopped. The written directive was changed and the correct site was treated. The Pennsylvania Department of Environmental Protection was notified and suggested that while all treatment team members are present during a "time out" procedure, to have the patient state the side of his/her lesion or treatment and place an imaging marker to designate the treatment side. The State is tracking the incident as number PA090027.

Event Da	te: C	7/29/2009	Discovery	Date	: 07/29/2009	Report Date:	07/29/2009
Licensee/Reporting Party Inf	ormat	ion:					
Agreement State Regulated:	YS		Recip	procity	: NONE		
License Number:	PA-02	264	Nam	e:	LEHIGH VALLEY	HOSPITAL	
NRC Docket Number:	NA		City:		BETHLEHEM		
NRC Program Code:	NA		State	: PA	Zip Code: NR		
Responsible NRC Region:	1						
Site of Event:							
Site Name: BETHLEHEM							
State: PA							
Additional Involved Party:							
License Number:	NA		Nam	e:	NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State	: NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abno	rmal C	Occurrence:	Ν	
Agreement State Reportable	Event	: Y	Inves	tigatio	n:	Y	
Atomic Energy Act Material:		Y	NME	D Rec	ord Complete:	Y	
Consultant Hired:		Ν	Even	t Close	ed by Region/State:	Ν	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Number:	1		<i>c</i> ,						
Patient Informed: L	J	Date In	formed:						
Given:									
Therapeutic Procee	dure: GAMMA	A KNIFE							
Organ:	BRAIN								
Radiopharmaceutic	al: NA								
Radionuclide: CC	-60	A	Activity:	NR mCi		NR MBq	Dose:	0 rad	0 Gy
Intended:									
Therapeutic Procee		A KNIFE							
Organ:	BRAIN								
Radiopharmaceutic							_		
Radionuclide: CC	0-56	Ą	Activity:	NR mCi		NR MBq	Dose:	4250 rad	42.5 Gy
% Dose Exceeds P	rescribed:	NA							
% Dose is Less Tha	an Prescribed	d: 100							
Effect on Patient:									
Patient Number:	1A								
Patient Informed: L	J	Date In	formed:						
Given:									
Therapeutic Proced	lure [.] GAMMA								
Organ:	BRAIN								
Radiopharmaceutic									
Radionuclide: CC		A	Activity:	NR mCi		NR MBq	Dose:	3450 rad	34.5 Gy
						•			,
% Dose Exceeds P % Dose is Less Th		100 d: NA							
Effect on Patient:									
Source of Radiation	:								
MD2									
Source Number:	1								
Source/Radioactive	Material: S	EALED S	OURCE GAMMA 🛛	NIFE	Radio	onuclide or '	Voltage (k∖	/p/MeV): CO-60	
Manufacturer:	Ν	R			Activ	ity:		NR Ci	NR GBq
Model Number:	Ν	R							
Serial Number:	N	R							
Device/Associated E	Equipment:								
Device Number:	1								
Device Name:	GAMMA KN	IFE UNIT			Mode	el Number:	Ν	IR	
Manufacturer:	NR				Seria	al Number:	Ν	IR	
References:									
Reference Numbe	r: Entry I	Data:	Retraction Date:	Coder Initi	aler	Reference	Tuno		
EN45241	08/10/2		08/28/2009	DCH	a15.			ON REPORTED F	
	00/10/2		0012012003	DOIT			ENT STATE		
LTR090827	08/27/2	2009		DCH		NRC LETT			
LTR090827A	08/27/2			DCH		NRC LETT	TER		
EN45241A	08/31/2	2009	08/28/2009	DCH		EVENT NO	OTIFICATIO	ON REPORTED F	ROM AN
						AGREEME	ENT STATE	Ξ	

Narrative:

Memorial Hospital reported that a patient received two doses of TI-201 instead of one dose for a diagnostic cardiovascular procedure on 6/16/2009. Each dose contained 0.27 GBq (7.2 mCi). Two nuclear medicine technologists were working in the same room. The second technologist misunderstood that the first technologist had already delivered the first dose. The estimated maximum internal organ dose received by the patient was 9.36 cSv (rem). Corrective actions included placing the patient's label on the dose, storing the doses in the hot laboratory until needed, requiring that the technologists verify injections that are written on orders, and tracking doses on a patient's work flow sheet.

Event Dat	t e: 06	6/16/2009	Discov	very Date:	06/16/2009	Report Date:	06/16/2009
Licensee/Reporting Party Inf	ormatio	on:					
Agreement State Regulated:	YS		Re	eciprocity:	NONE		
License Number:	FL-256	67-1	Na	ame:	MEMORIAL HOSP	ITAL	
NRC Docket Number:	NA		Ci	ity:	JACKSONVILLE		
NRC Program Code:	NA		St	ate: FL	Zip Code: 32216		
Responsible NRC Region:	1						
Site of Event:							
Site Name: JACKSONVILLE	Ξ						
State: FL							
Additional Involved Party:							
License Number:	NA		Na	ame:	NA		
NRC Docket Number:	NA		Ci	ity:	NA		
NRC Program Code:	NA		St	ate: NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	At	onormal O	ccurrence:	Ν	
Agreement State Reportable	Event:	Y	In	vestigation	1:	Y	
Atomic Energy Act Material:		Y	N	MED Reco	rd Complete:	Y	
Consultant Hired:		Ν	E١	vent Close	d by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action:

MD2

1 IMPROVE RADIOACTIVE MATERIAL LABELING AND HANDLING

2 PROCEDURE MODIFIED

Patient Number: 1						
Patient Informed: U	Date I	nformed:				
Given:						
Diagnostic Study:	CARDIOVASCU	LAR SYSTEM				
Radiopharmaceutical:	THALLOUS CHI	ORIDE				
Radionuclide: TL-201	1	Activity: 1	4.4 mCi	532.8 MBq		
Intended:						
Diagnostic Study:	CARDIOVASCU	LAR SYSTEM				
Radiopharmaceutical:	THALLOUS CHI	ORIDE				
% Dose Exceeds Pres	cribed: NA					
% Dose is Less Than F						
Effect on Patient:						
Source of Radiation:						
MD2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEALE	ED SOURCE RADIO	OPHARM Ra	adionuclide or Voltage (kVp/	/MeV): TL-201	
Manufacturer:	NR		Ac	tivity:	0.0144 Ci	0.5328 GBq
Model Number:	NA					
Serial Number:	NA					
Keywords:						
MD2						
REVISED BYPRODUC	T MATERIAL DE	FINITION				
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
EN45135	06/22/2009		DCH	EVENT NOTIFICATION AGREEMENT STATE	REPORTED FRO	M AN
FL09-052	04/15/2010		DCH	AGREEMENT STATE	EVENT REPORT	

Last Updated: 01/12/2010

Narrative:

Saint Johns Mercy Medical Center reported that a patient, undergoing brachytherapy treatment of the prostate on 5/21/2009, only received six of the prescribed 88 seeds. The seeds each contained 10.66 MBq (0.288 mCi) of I-125. The procedure was aborted because of concerns in placing additional needles into the patient. The prescribed dose was 14,500 cGy (rad). Family members were notified of the aborted procedure. This event was retracted on 5/22/2009, because the physician made a choice to terminate the brachytherapy treatment. The physician then rewrote the procedure to the patient to limit the prescribed number of seeds to six. With six seeds implanted into the patient, the prescribed dose was now met under the revised written directive.

Event Dat	e: 0	5/21/2009	Discovery Dat	e: 05/21/2009	Report D	ate: 0	5/22/2009	
Licensee/Reporting Party Inf Agreement State Regulated: License Number: NRC Docket Number:	NO	794-03	Reciprocil Name: City:	IY: NONE SAINT JOHNS ME SAINT LOUIS		CAL CENT	ĒR	
NRC Program Code: Responsible NRC Region:	02120 3		State: M	O Zip Code: 63141				
Site of Event: Site Name: SAINT LOUIS State: MO								
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code:	NA NA NA		Name: City: State: N/	NA NA A Zip Code: NA				
Responsible NRC Region:	NA							
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:	Event:	N N Y N	Investigat NMED Re	Occurrence: ion: ecord Complete: sed by Region/State:	N N Y			
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROF Corrective Actions Information Action Number: Corrective MD2 1 NOT REPO	on: Action							
Patient Information: Patient Number: 1 Patient Informed: Y	г	Date Informed: 05/2	1/2009					
Given: Therapeutic Procedure: BRA		MANUAL IMPLANT	1.73 mCi	64.01 MBq	Dose:	NR rad	d NR Gy	
Intended: Therapeutic Procedure: BRA Organ: PRC Radiopharmaceutical: NA Radionuclide: I-125	(CHY, I STATI		25.34 mCi	937.58 MBq	Dose:	14500 rad	d 145 Gy	
% Dose Exceeds Prescribed % Dose is Less Than Prescr Effect on Patient:		NA 93.17						

Source of Radiation:						
MD2						
Source Number:	1					
Source/Radioactive Ma	terial: SEALED	SOURCE BRACHYT	HERAPY R	adionuclide or Voltage (kVp/MeV): I-125	
Manufacturer:	NR		A	ctivity:	0.02534 Ci	0.93758 GBq
Model Number:	NR					
Serial Number:	AGGRE	GATE				
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials	Reference Type:		
EN45089	05/28/2009	05/22/2009	DCH	EVENT NOTIFICAT	ΓΙΟΝ	
LTR091231	01/06/2010		DCH	NRC LETTER		

DCH

NRC LETTER

LTR100112

01/12/2010

Narrative:

During an inspection at MP Diagnostic, it was found that two patient's were given I-123 treatments greater than 20% above the prescribed amount of 7.4 MBq (200 uCi) on or about 4/2/2009. One patient received 11.77 MBq (318 uCi) and the other patient received 11.62 MBq (314 uCi). It was determined that DP Diagnostic was using dose ranges not acceptable by regulation. Corrective actions included implementing correct dosage protocols and maintaining administration records in an auditable fashion.

implementing correct dosage	protocols and maintaining ac	iministration i	records in an auditat	ble fashion.	
Event Date	: 04/02/2009 Dis	scovery Date	: 04/02/2009	Report Date:	04/02/2009
Licensee/Reporting Party Info	rmation:				
Agreement State Regulated: `	YS	Reciprocity	: NONE		
License Number:	FL-3407-1	Name:	MP DIAGNOSTIC,	, LTD	
NRC Docket Number:	NA	City:	MIAMI		
NRC Program Code:	NA	State: FL	Zip Code: 33176		
Responsible NRC Region:	1				
Site of Event:					
Site Name: MIAMI					
State: FL					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal (Occurrence:	Ν	
Agreement State Reportable E	Event: Y	Investigatio	on:	Υ	
Atomic Energy Act Material:	Y	NMED Rec	ord Complete:	Υ	
Consultant Hired:	Ν	Event Clos	ed by Region/State:	Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: DEFECTIVE OR I	INADEQUATE PROCEDURE	<u>:</u>			
Corrective Actions Information	n:				
Action Number: Corrective	Action:				
MD2					
1 PROCEDU	RE MODIFIED				
Patient Information: Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: NR					

0.318 mCi

11.766 MBq

Radiopharmaceutical: SODIUM IODIDE Radionuclide: I-123 A

Intended:

Diagnostic Study:	NR			
Radiopharmaceutical: Radionuclide: I-123	SODIUM IC	DDIDE Activity:	0.2 mCi	7.4 MBq
% Dose Exceeds Preso	cribed:	59		
% Dose is Less Than P	rescribed:	NA		

Activity:

Effect on Patient:

Patient Number: 2								
Patient Informed: U		Date Informed:						
Given:								
Diagnostic Study:	NR							
Radiopharmaceutical:	SODIUM	I IODIDE						
Radionuclide: I-123		Activity:	0.31	4 mCi	11.6	618 MBq		
Intended:								
Diagnostic Study:	NR							
Radiopharmaceutical:	SODIUM	I IODIDE						
Radionuclide: I-123		Activity:	0.	2 mCi		7.4 MBq		
% Dose is Less Than F Effect on Patient: Source of Radiation: MD2	Prescribed	i: NA						
Source Number:	1							
Source/Radioactive Ma			E RADIOF	PHARM		onuclide or Voltage (k)	• •	
Manufacturer:	N				Activ	ity:	0.000318 Ci	0.011766 GBq
Model Number:	N/							
Serial Number:	N	A						
Source Number:	2							
Source/Radioactive Ma	aterial: UI	NSEALED SOURC	E RADIOF	PHARM	Radio	onuclide or Voltage (k)	/p/MeV): I-123	
Manufacturer:	N	R			Activ	ity:	0.000314 Ci	0.011618 GBq
Model Number:	N/	A						
Serial Number:	N	A						
Keywords:								
MD2								
REVISED BYPRODUC	T MATER	RIAL DEFINITION						
References:								
Reference Number:	Entry D	Date: Retractio	n Date:	Coder Initia	als:	Reference Type:		
EN44953	04/08/2	2009		RLS		EVENT NOTIFICATION		Rom an
LTR090713	07/14/2	2009		DCH		AGREEMENT STAT	E LETTER	
FL09-032	07/28/2	2009		DCH		AGREEMENT STAT	E EVENT REPORT	

Narrative:

The Department of Veterans Affairs reported that a prostate seed implant patient received a dose to an unintended site on 2/12/2009 at the Veterans Affairs Greater Los Angeles Healthcare System in Los Angeles, California. The patient was implanted with 108 I-125 seeds with a total activity of approximately 1.44 GBq (39 mCi) to deliver a prescribed dose of 14,500 cGy (rad) to the prostate. Post-implant imaging revealed that five I-125 seeds containing 66.6 MBq (1.8 mCi) were mistakenly placed more than 1 cm outside the prostate in the patient's perineum. The dose to the prostate was within 80% of the prescribed dose. The patient was notified on 2/13/2009. The prostate implant program was suspended until a causal analysis is completed. This event was caused by the physician's technique. In addition, this was a training case for a resident, who may have implanted the seeds. On 2/10/2010, the NRC requested additional patient dose data. The reassessed doses to the patients' rectum and periprostatic tissue were less than the prescribed dose to the prostate. Therefore, this event is not reportable.

Event Dat	e: 02	2/12/2009	Disco	overy Date:	02/12/2009	Report Date:	02/13/2009
Licensee/Reporting Party Inf	ormati	on:					
Agreement State Regulated:	NO		F	Reciprocity:	NONE		
License Number:	03-238	353-01VA	1	Name:	DEPARTMENT OF	VETERANS AFF	AIRS
NRC Docket Number:	03034	325	(City:	NORTH LITTLE R	OCK	
NRC Program Code:	03613		5	State: AR	Zip Code: 72114		
Responsible NRC Region:	3						
Site of Event:							
Site Name: LOS ANGELES							
State: CA							
Additional Involved Party:							
License Number:	NA		1	Name:	NA		
NRC Docket Number:	NA		(City:	NA		
NRC Program Code:	NA		5	State: NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	ŀ	Abnormal O	ccurrence:	Ν	
Agreement State Reportable	Event:	Ν	I	nvestigatior	ו:	Y	
Atomic Energy Act Material:		Y	1	MED Reco	ord Complete:	Υ	
Consultant Hired:		Ν	E	Event Close	d by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2 1 NOT REPORTED

Patient Number: 1							
Patient Informed: Y	Date	Informed: 02/13/200	9				
Given:							
Therapeutic Procedure	: BRACHY, MAN	IUAL IMPLANT					
Organ:	PERINEUM						
Radiopharmaceutical:	NA						
Radionuclide: I-125		Activity: 1	.8 mCi	66.6 MBq	Dose:	NR rad	NR Gy
Intended:							
Therapeutic Procedure	: BRACHY, MAN	IUAL AFTERLOADEF	२				
Organ:	PROSTATE						
Radiopharmaceutical:	NA						
Radionuclide: I-125		Activity:	39 mCi 1	1443 MBq	Dose:	14500 rad	145 Gy
% Dose Exceeds Preso % Dose is Less Than F Effect on Patient:		-					
Source of Radiation:							
MD2							
Source Number:	1						
Source/Radioactive Ma		SOURCE BRACHYT			Voltage (k	Vp/MeV): I-125	
Manufacturer:	NR		Acti	vity:		0.0018 Ci	0.0666 GBq
Model Number:	NR						
Serial Number:	AGGREC	JAIE					
References:							
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference	e Type:		
EN44853	02/19/2009		DCH	EVENT N	OTIFICAT	ION	
ML090570368	08/07/2009		RLS	LICENSE	E REPOR	Г	
ML101440380	05/26/2010		RLS	INSPECT	ION REPO	DRT	
ML101440380	05/26/2010		RLS	NRC LET	TER		
LTR100603	06/09/2010		DCH	NRC LET	TER		
ML101880329	07/20/2010		RLS	ENFORC	EMENT CO	ONFERENCE	
ML101880329	07/20/2010		RLS	NRC LET	TER		
ML101970407	08/16/2010		RLS	LICENSE	E REPOR	Г	
ML102350127	08/24/2010		RLS	NOTICE (OF VIOLA	ΓΙΟΝ	
ML102350127	08/24/2010		RLS	NRC LET	TER		
ML102350261	08/24/2010		RLS	NRC NEV	VS ANNOL	JNCEMENT	
ML102300006	09/01/2010		RLS	NOTIFICA ACTION	TION OF	SIGNIFICANT ENF	ORCEMENT
ML102430195	09/01/2010		RLS	LICENSE	E REPOR	Г	

Narrative:

The Department of Veterans Affairs reported two medical events involving patients who had undergone permanent implant prostate seed brachytherapy in 2005 at the Greater Los Angeles Healthcare System in Los Angeles, California. The events were discovered during a review on 1/27/2009. The first event occurred on 6/8/2005 when a patient was implanted with 62 I-125 seeds containing a total activity of 0.75 GBq (20.3 mCi) to deliver a prescribed prostate dose of 14,500 cGy (rad). However, 10 seeds were later determined to be outside the prostate and delivered a dose initially estimated to be 14,500 cGy (rad) to a 0.36 cm3 volume of the rectum. The second case occurred on 11/23/2005 when a patient was implanted with 88 I-125 seeds containing a total activity of 1.07 GBq (28.8 mCi) to deliver a prescribed dose of 14,500 cGy (rad) to a 0.36 cm3 volume of the rectum. The second case occurred on 11/23/2005 when a patient was implanted with 88 I-125 seeds containing a total activity of 1.07 GBq (28.8 mCi) to deliver a prescribed dose of 14,500 cGy (rad) to a 0.77 cm3 volume of the rectum. In both cases, the dose delivered to the intended treatment site was within 80% of the prescribed dose. The causes of these events were the poor quality of the ultrasound unit that was used during the procedures and the lack of a structured resident training program in prostate brachytherapy. Both patients were notified of the events and no adverse effects to the patients are expected. Corrective actions included procedure modification and obtaining a new trans-rectal ultrasound unit capable of providing high quality images. On 2/10/2010, the NRC requested additional patient dose data. The reassessed doses to the patients' rectum and periprostatic tissue were less than the prescribed dose to the prostate. Therefore, these events are not reportable.

Event Da	te: 06/0	08/2005	Discovery Date:	01/27/2009	Report Date:	01/28/2009					
Licensee/Reporting Party In	Licensee/Reporting Party Information:										
Agreement State Regulated:	NO		Reciprocity	NONE							
License Number:	03-2385	3-01VA	Name:	DEPARTMENT O	F VETERANS AFF.	AIRS					
NRC Docket Number:	0303432	25	City:	NORTH LITTLE R	OCK						
NRC Program Code:	03613		State: AR	Zip Code: 72114							
Responsible NRC Region:	3										
Site of Event:											
Site Name: LOS ANGELES											
State: CA											
Additional Involved Party:											
License Number:	NA		Name:	NA							
NRC Docket Number:	NA		City:	NA							
NRC Program Code:	NA		State: NA	Zip Code: NA							
Responsible NRC Region:	NA										
Other Information:											
NRC Reportable Event:	1	N	Abnormal C	occurrence:	Ν						
Agreement State Reportable	Event: N	N	Investigatio	n:	Y						
Atomic Energy Act Material:	١	(NMED Rec	ord Complete:	Y						
Consultant Hired:	1	N	Event Close	ed by Region/State:	Y						

Event Type:

MD2 - MEDICAL EVENT

Event Cause:

Cause: DEFECTIVE OR INADEQUATE PROCEDURE

Corrective Actions Information:

Action Number: Corrective Action:

- MD2
- 1 PROCEDURE MODIFIED
- 2 NEW EQUIPMENT OBTAINED

MD2

Patient Number: 1								
Patient Informed: Y		Date Informed: 07	/28/2009					
Given:								
Therapeutic Procedure	: BRACHY	, MANUAL IMPLAN	IT					
Organ:	RECTUM							
Radiopharmaceutical:								
Radionuclide: I-125		Activity:	3.27 m	nCi 120	99 MBq	Dose:	NR rad	NR Gy
		, totivity.	0.27 11	120.	oo mbq	2000.		int oy
Intended:								
Therapeutic Procedure	: BRACHY	, MANUAL AFTER	OADER					
Organ:	PROSTA	TE						
Radiopharmaceutical:	NA							
Radionuclide: I-125		Activity:	20.3 m	nCi 75'	I.1 MBq	Dose:	14500 rad	145 Gy
% Dose Exceeds Pres	cribed:	NA						
% Dose is Less Than F	Prescribed:	NA						
Effect on Patient:								
Patient Number: 2								
Patient Informed: Y		Date Informed: 0 ²	120/2000					
Patient mormed.		Date mormed. 0	129/2009					
Given:								
Therapeutic Procedure			IT					
Organ:	RECTUM	l						
Radiopharmaceutical:	NA							
Radionuclide: I-125		Activity:	4.25 m	nCi 157.	25 MBq	Dose:	NR rad	NR Gy
lute a de de								
Intended:								
Therapeutic Procedure								
Organ:	PROSTA	IE						
Radiopharmaceutical:	NA							
	100	A 11 11		0		_	44500	445 0
Radionuclide: I-125		Activity:	28.8 m	nCi 1065	5.6 MBq	Dose:	14500 rad	145 Gy
		Activity:	28.8 m	nCi 1065	5.6 MBq	Dose:	14500 rad	145 Gy
Radionuclide: I-125	cribed:	NA	28.8 m	nCi 1068	5.6 MBq	Dose:	14500 rad	145 Gy
Radionuclide: I-125 % Dose Exceeds Press	cribed:	NA	28.8 m	nCi 1065	5.6 MBq	Dose:	14500 rad	145 Gy
Radionuclide: I-125 % Dose Exceeds Press % Dose is Less Than F	cribed:	NA	28.8 m	nCi 1065	5.6 MBq	Dose:	14500 rad	145 Gy
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient:	cribed:	NA	28.8 m	nCi 1065	5.6 MBq	Dose:	14500 rad	145 Gy
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: fource of Radiation:	cribed:	NA	28.8 m	nCi 1065	5.6 MBq	Dose:	14500 rad	145 Gy
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2	cribed: Prescribed:	NA NA					14500 rad	145 Gy
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number:	cribed: Prescribed:	NA NA ALED SOURCE BF			nuclide or			145 Gy 120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma	cribed: Prescribed: 1 aterial: SE	NA NA ALED SOURCE BF		APY Radic	nuclide or		:Vp/MeV): I-125	
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: 1D2 Source Number: Source/Radioactive Ma Manufacturer:	cribed: Prescribed: 1 aterial: SE NR NR	NA NA ALED SOURCE BF		APY Radic	nuclide or		:Vp/MeV): I-125	
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: 1D2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number:	tribed: Prescribed: Aterial: SE NR NR AG	NA NA ALED SOURCE BF		APY Radic	nuclide or		:Vp/MeV): I-125	
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number:	cribed: Prescribed: aterial: SE NR NR AG 2	NA NA ALED SOURCE BF	RACHYTHER	APY Radic Activi	nuclide or	Voltage (k	:Vp/MeV): I-125	
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: fource of Radiation: 1D2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma	rribed: Prescribed: Aterial: SE NR AG 2 aterial: SE	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF	RACHYTHER	APY Radic Activi APY Radic	nuclide or ty: nuclide or	Voltage (k	XVp/MeV): I-125 3.27 Ci XVp/MeV): I-125	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: MD2 Source Number: Source/Radioactive Ma Manufacturer: Source Number: Serial Number: Source/Radioactive Ma Manufacturer:	tribed: Prescribed: Aterial: SE NR AG 2 aterial: SE NR	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF	RACHYTHER	APY Radic Activi	nuclide or ty: nuclide or	Voltage (k	:Vp/MeV): I-125 3.27 Ci	
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: fource of Radiation: 1D2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma	tribed: Prescribed: Aterial: SE NR AG 2 Aterial: SE NR NR NR	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF	RACHYTHER	APY Radic Activi APY Radic	nuclide or ty: nuclide or	Voltage (k	XVp/MeV): I-125 3.27 Ci XVp/MeV): I-125	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: Ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Source/Radioactive Ma	tribed: Prescribed: Aterial: SE NR AG 2 Aterial: SE NR NR NR	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF	RACHYTHER	APY Radic Activi APY Radic	nuclide or ty: nuclide or	Voltage (k	XVp/MeV): I-125 3.27 Ci XVp/MeV): I-125	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: fource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Serial Number: Serial Number:	tribed: Prescribed: Aterial: SE NR AG 2 Aterial: SE NR NR AG	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF	RACHYTHER RACHYTHER	APY Radic Activi APY Radic Activi	nuclide or ty: nuclide or ty:	Voltage (k Voltage (k	XVp/MeV): I-125 3.27 Ci XVp/MeV): I-125	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Serial Number: Serial Number: Serial Number:	tribed: Prescribed: Prescribed: NR Aderial: SE NR AG NR AG AG Entry Da	NA NA ALED SOURCE BF GREGATE GREGATE GREGATE ate: Retraction	RACHYTHER RACHYTHER Date: Co	APY Radic Activi APY Radic Activi der Initials:	nuclide or ty: nuclide or ty: Referenc	Voltage (k Voltage (k e Type:	(Vp/MeV): I-125 3.27 Ci (Vp/MeV): I-125 4.25 Ci	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number:	tribed: Prescribed: Aterial: SE NR AG 2 Aterial: SE NR AG 2 Entry Da 02/03/20	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF GREGATE GREGATE ALED SOURCE BF	RACHYTHER RACHYTHER Date: Co DC	APY Radic Activi APY Radic Activi der Initials:	nuclide or ty: nuclide or ty: Referenc EVENT N	Voltage (k Voltage (k e Type: OTIFICAT	«Vp/MeV): I-125 3.27 Сі «Vp/MeV): I-125 4.25 Сі	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number:	tribed: Prescribed: Aterial: SE NR AG 2 aterial: SE NR AG 2 02/03/20 02/03/20 02/23/20	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF GREGATE ate: Retraction 009	ACHYTHER ACHYTHER Date: Co DC RL	APY Radic Activi APY Radic Activi der Initials: H S	nuclide or ty: nuclide or ty: Referenc EVENT N LICENSE	Voltage (k Voltage (k e Type: OTIFICAT E REPOR	xVp/MeV): I-125 3.27 Ci xVp/MeV): I-125 4.25 Ci ION T	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number:	tribed: Prescribed: Prescribed: NR Aterial: SE NR AG 2 2 2 2 2 2 4 2 2 2 4 2 2 2 2 4 2	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF GREGATE ate: Retraction	RACHYTHER RACHYTHER Date: Co DC RL RL	CAPY Radic Activit CAPY Radic Activit der Initials: CH .S .S	nuclide or ty: nuclide or ty: Referenc EVENT N LICENSE INSPECT	Voltage (k Voltage (k e Type: OTIFICAT E REPOR ION REPO	xVp/MeV): I-125 3.27 Ci xVp/MeV): I-125 4.25 Ci ION T	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number:	tribed: Prescribed: Aterial: SE NR AG 2 aterial: SE NR AG 02/03/20 05/26/20 05/26/20 05/26/20	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF GREGATE ate: Retraction 009 009 010	RACHYTHER RACHYTHER Date: Co DC RL RL RL	APY Radic Activi APY Radic Activi der Initials: S S S S	nuclide or ty: nuclide or ty: Referenc EVENT N LICENSE INSPECT NRC LET	Voltage (k Voltage (k e Type: OTIFICAT E REPOR ION REPO TER	xVp/MeV): I-125 3.27 Ci xVp/MeV): I-125 4.25 Ci ION T	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: Ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Num	tribed: Prescribed: Prescribed: NR AG 2 2 aterial: SE NR NR AG 2 02/03/20 02/23/20 05/26/20 05/26/20 05/26/20 06/09/20	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF GREGATE ate: Retraction 009 010 010	RACHYTHER RACHYTHER Date: Co DC RL RL DC	APY Radic Activit APY Radic Activit der Initials: CH S S S CH	nuclide or ty: nuclide or ty: Referenc EVENT N LICENSE INSPECT NRC LET NRC LET	Voltage (k Voltage (k OTIFICAT E REPOR ION REPO TER TER	(Vp/MeV): I-125 3.27 Ci (Vp/MeV): I-125 4.25 Ci ION T DRT	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number: Serial Number:	tribed: Prescribed: Aterial: SE NR AG 2 aterial: SE NR AG 02/03/20 05/26/20 05/26/20 05/26/20	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF GREGATE ate: Retraction 009 010 010	RACHYTHER RACHYTHER Date: Co DC RL RL DC RL RL DC RL	APY Radic Activi APY Radic Activi der Initials: CH S S CH S	nuclide or ty: Referenc EVENT N LICENSE INSPECT NRC LET NRC LET ENFORC	Voltage (k Voltage (k OTIFICAT E REPOR ION REPO TER TER EMENT C	xVp/MeV): I-125 3.27 Ci xVp/MeV): I-125 4.25 Ci ION T	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Num	tribed: Prescribed: Prescribed: NR AG 2 2 aterial: SE NR NR AG 2 02/03/20 02/23/20 05/26/20 05/26/20 05/26/20 06/09/20	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF GREGATE ate: Retraction 009 009 010 010	RACHYTHER RACHYTHER Date: Co DC RL RL DC RL RL RL RL RL RL	APY Radic Activit APY Radic Activit der Initials: CH S S S CH S S S	nuclide or ty: nuclide or ty: Referenc EVENT N LICENSE INSPECT NRC LET NRC LET	Voltage (k Voltage (k OTIFICAT E REPOR ION REPO TER TER EMENT C	(Vp/MeV): I-125 3.27 Ci (Vp/MeV): I-125 4.25 Ci ION T DRT	120.99 GBq
Radionuclide: I-125 % Dose Exceeds Prese % Dose is Less Than F Effect on Patient: OUTCE of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Num	tribed: Prescribed: Aterial: SE NR AG 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	NA NA ALED SOURCE BF GREGATE ALED SOURCE BF GREGATE ate: Retraction 009 009 010 010 010 010	RACHYTHER RACHYTHER Date: Co DC RL RL DC RL RL DC RL	APY Radic Activit APY Radic Activit der Initials: CH S S S CH S S S	nuclide or ty: nuclide or ty: Referenc EVENT N LICENSE INSPECT NRC LET NRC LET ENFORC NRC LET	Voltage (k Voltage (k OTIFICAT E REPOR ION REPO TER TER EMENT C	(Vp/MeV): I-125 3.27 Ci (Vp/MeV): I-125 4.25 Ci ION T DRT ONFERENCE	120.99 GBq

ML102350127	08/24/2010	RLS	NRC LETTER
ML102350261	08/24/2010	RLS	NRC NEWS ANNOUNCEMENT
ML102300006	09/01/2010	RLS	NOTIFICATION OF SIGNIFICANT ENFORCEMENT ACTION
ML102430195	09/01/2010	RLS	LICENSEE REPORT

Narrative:

Jewish Hospital Louisville (JHL) reported injecting an 89 year old patient with 92.5 MBq (2.5 mCi) of In-111 DTPA instead of the prescribed 18.5 MBq (0.5 mCi) for a cisternogram procedure. The procedure was performed on 12/14/2008 and the technologist present had not previously participated in that type of procedure. The dose vial delivered by the pharmacy was assayed at 118.4 MBq (3.2 mCi) and given to the radiologist for intrathecal injection. JHL calculated that the dosage received by the patient was 92.5 MBq (2.5 mCi).

the radiologist for intrathecal	injection. JHL calculated th	at the dosage rec	eived by the patie	ent was 92.5 MBq (2.5 mCi).
Event Dat	e: 12/14/2008 E	iscovery Date:	12/14/2008	Report Date:	12/15/2008
Licensee/Reporting Party Infe	ormation:				
Agreement State Regulated:	YS	Reciprocity: N	NONE		
License Number:	KY-201-115-22	Name:	IEWISH HOSPITA	L LOUISVILLE	
NRC Docket Number:	NA	City: L	OUISVILLE		
NRC Program Code:	NA	State: KY 2	Zip Code: 40202		
Responsible NRC Region:	1				
Site of Event:					
Site Name: LOUISVILLE					
State: KY					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA		NA		
NRC Program Code:	NA	,	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:	N	Abactural Or		N	
NRC Reportable Event:	N Fuentu X	Abnormal Oc		N	
Agreement State Reportable		Investigation:		N	
Atomic Energy Act Material:	Y	NMED Recor		Y	
Consultant Hired:	N	Event Closed	by Region/State:	N	
Event Type:					
MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
Cause: HUMAN ERROR	ł				
Corrective Actions Information	on:				
Action Number: Corrective	Action:				
MD2					
1 NOT REPO	ORTED				
Patient Information:					
Patient Number: 1					
Patient Informed: Y	Date Informed: 12/15	/2008			
r dient morned.	Date monned. 12/10	2000			
Given:					
Diagnostic Study: CIST	TERNOGRAM				
Radiopharmaceutical: DTP	A (DIETHYLTRIAMINE-PEN	ITAACE			
Radionuclide: IN-111	Activity:	2.5 mCi	92.5 MBq		
Intended:					
Diagnostic Study: CIST	TERNOGRAM				
Radiopharmaceutical: DTP	A (DIETHYLTRIAMINE-PEN	ITAACE			
Radionuclide: IN-111	Activity:	0.5 mCi	18.5 MBq		
% Dees Evented Dented "					
% Dose Exceeds Prescribed					
% Dose is Less Than Prescri	ibed: NA				
Effect on Patient:					
Source of Radiation:					

Source Number: 1						
Source/Radioactive Material:	UNSEALED	SOURCE RADIOF	PHARM Rac	lionuclide or Voltage (kVp/	MeV): IN-111	
Manufacturer:	NR		Acti	vity:	0.0025 Ci	0.0925 GBq
Model Number:	NA					
Serial Number:	NA					
Keywords:						
MD2						
REVISED BYPRODUCT MA	TERIAL DEFI	NITION				
References:						
	ry Date: F 09/2009	Retraction Date:	Coder Initials: DCH	Reference Type: AGREEMENT STATE E	VENT REPORT	

Narrative:

Trinitas Hospital reported that a patient possibly received a medical dose that was less than 50% of the prescribed dose. They suspected movement of the catheter during an endobronchial high dose rate (HDR) remote afterloading treatment procedure, which may have resulted in a single fraction differing from the prescribed dose by more than 50%. Both the patient and the referring physician were notified by the authorized user. The patient had an endobronchial catheter placed in the right bronchus. The patient received a CT scan to determine the catheter location and treatment dwell positions. The patient was monitored by nurses during the treatment planning process. The patient received the treatment and was disconnected from the HDR unit. The technologist that removed the catheter from the patient noted that it was not at the intended location. The patient may have dislodged the catheter when coughing or wiping mouth secretions. The pulmonologist and authorized user will perform a bronchoscopy in two weeks to determine if a medical event occurred. Corrective actions included requiring that the authorized user remove all endobronchial catheter at planning CT and both pre and post treatment, and measure the catheter in the patient, check marked position of the catheter at planning CT and both pre and post treatment, and based on the patient's clinical response, which suggests that the catheter was correctly positioned during the treatment.

Event Da	te: 12	2/17/2008	Discov	ery Date:	12/17/2008	Report Date:	12/18/2008					
Licensee/Reporting Party Information:												
Agreement State Regulated:	NO		Re	ciprocity:	NONE							
License Number:	29-043	33-01	Na	ame:	TRINITAS HOSPIT	AL						
NRC Docket Number:	03002	476	Ci	ty:	ELIZABETH							
NRC Program Code:	02120		St	ate: NJ	Zip Code: 07207							
Responsible NRC Region:	1											
Site of Event: Site Name: ELIZABETH State: NJ												
Additional Involved Party:												
License Number:	NA		Na	ame:	NA							
NRC Docket Number:	NA		Ci	ty:	NA							
NRC Program Code:	NA		St	ate: NA	Zip Code: NA							
Responsible NRC Region:	NA											
Other Information:												
NRC Reportable Event:		Ν	Ab	normal O	ccurrence:	Ν						
Agreement State Reportable	Event:	Ν	Inv	estigation/	1:	Ν						
Atomic Energy Act Material:		Y	N	/IED Reco	rd Complete:	Y						
Consultant Hired:		Ν	Ev	ent Close	d by Region/State:	Ν						

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2

Cause: NOT REPORTED

Corrective Actions Information:

Action Number: Corrective Action:

MD2

1 PROCEDURE MODIFIED

Patient Number: 1							
Patient Informed: Y	Date	Informed: 12/18/20	800				
Given:							
Therapeutic Procedure	BRACHY, REM	IOTE AFTERLOAD	ER, HDR				
Organ:	BRONCHUS						
Radiopharmaceutical:	NA						
Radionuclide: NR		Activity:	NR mCi	NR MBq	Dose:	NR rad	NR Gy
Intended:							
Therapeutic Procedure	: BRACHY, REM	IOTE AFTERLOAD	ER, HDR				
Organ:	BRONCHUS						
Radiopharmaceutical:	NA						
Radionuclide: NR		Activity:	NR mCi	NR MBq	Dose:	NR rad	NR Gy
% Dose Exceeds Pres % Dose is Less Than F Effect on Patient: Source of Radiation: MD2 Source Number: Source/Radioactive Ma	Prescribed: NF 1 aterial: SEALED	2		Radionuclide or	Voltage (kV	. ,	
Manufacturer:	NR			Activity:		NR Ci	NR GBq
Model Number:	NR						
Serial Number:	NR						
Device/Associated Equ MD2 Device Number: 1	ipment:						
Device Number: REMOTE AFTERLOADER HDR Manufacturer: NR					R R		
References: Reference Number: EN44733 EN44733A	Entry Date: 12/24/2008 01/05/2009	Retraction Date: 12/31/2008 12/31/2008	: Coder Initial DCH DCH	EVENT N	e Type: OTIFICATIC OTIFICATIC		

Effect on Patient:

Narrative:

Nevada Physicians Imaging (NPI) reported inadvertently administering 8.14 MBq (220 uCi) of I-123 to the wrong patient. The intended patient was scheduled to receive a thyroid scan. The wrong patient shared the same name as the intended patient. As a result, the wrong patient underwent a thyroid scan. It is unknown what procedure the wrong patient was to receive. The patient has not been notified of the incorrect treatment. NPI will notify the prescribing physician. The Nevada State Health Department investigated the incident. NPI estimated the dose to the wrong patient at 3.56 cGy (rad) to the thyroid. Corrective actions included confirming a patient's name and birth date by scheduling staff and the nuclear medicine technologist prior to any nuclear medicine administration.

Event D	Date: 11/21/2008	Discovery Date:	11/21/2008	Report Date:	11/21/2008
Licensee/Reporting Party I Agreement State Regulate License Number: NRC Docket Number: NRC Program Code:		Reciprocity: Name: City: State: NV	NONE NEVADA PHYSIC LAS VEGAS Zip Code: NR	CIANS IMAGING	
Responsible NRC Region: Site of Event: Site Name: LAS VEGAS State: NV	4				
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Materia Consultant Hired:				N Y Y : Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERR	OR				
Corrective Actions Informa Action Number: Correcti MD2 1 PROCE					
Patient Information: Patient Number: 1 Patient Informed: N	Date Informed:				
Given: Diagnostic Study: TI	HYROID IMAGING				
Radiopharmaceutical: Si Radionuclide: I-123	ODIUM IODIDE Activity:	0.22 mCi	8.14 MBq		
Diagnostic Study: N Radiopharmaceutical: N					
Radionuclide: NR % Dose Exceeds Prescrib % Dose is Less Than Pres		NR mCi	NR MBq		

Source of Radiation:				
MD2				
Source Number: 1				
Source/Radioactive Mater	ial: UNSEAL	ED SOURCE RADIO	PHARM F	Radionuclide or Voltage (kVp/MeV): I-123
Manufacturer:	NR		A	Activity: 0.00022 Ci 0.00814 GBq
Model Number:	NA			
Serial Number:	NA			
Keywords:				
MD2				
REVISED BYPRODUCT	MATERIAL DE	FINITION		
References:				
Reference Number:	Entry Date:	Retraction Date:	Coder Initials	s: Reference Type:
EN44677	12/01/2008		DCH	EVENT NOTIFICATION REPORTED FROM AN AGREEMENT STATE
LTR090206 0	2/09/2009		DCH	AGREEMENT STATE LETTER

Narrative:

South Texas Radiology Imaging Centers reported that a patient was mistakenly administered 0.14 GBq (3.8 mCi) of I-131 on 9/2/2008 instead of the prescribed 1.11 GBq (30 mCi) of Tc-99m for a routine bone scan. In placing the order for a nuclear medicine study, the referring physician's receptionist had first checked "Bone Scan – Total Body," but then drew a line through that entry and marked "I-131 Whole Body Scan." The appropriateness of the study for the patient was not verified by the referring physician, the nuclear medicine technologist, or the authorized physician user. The error was discovered on 9/4/2008, when the patient returned to the center for imaging 48 hours after administration. The estimated dose to the patient's thyroid is 4,940 cSv (rem). The State Agency considers the incident reportable and lists it as meeting the Abnormal Occurrence criteria. However, the NRC determined that this was not a reportable event because the patient received the dose listed on the incorrect written directive. Corrective actions included reprimanding personnel, modifying procedures, and providing additional training to personnel.

Event Dat	te: 0	9/02/2008	Discovery	Date:	09/04/2008	Report Date:	10/02/2008
Licensee/Reporting Party Inf	ormati	on:					
Agreement State Regulated:	YS		Recipr	ocity:	NONE		
License Number:	TX-L0	0325	Name:		SOUTH TEXAS RA	ADIOLOGY IMAGII	NG CENTERS
NRC Docket Number:	NA		City:		SAN ANTONIO		
NRC Program Code:	NA		State:	ТΧ	Zip Code: 78229		
Responsible NRC Region:	4						
Site of Event:							
Site Name: SAN ANTONIO							
State: TX							
Additional Involved Party:							
License Number:	NA		Name:		NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State:	NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abnorr	nal O	ccurrence:	Ν	
Agreement State Reportable	Event:	Y	Investi	gatio	ו:	Y	
Atomic Energy Act Material:		Y	NMED	Reco	ord Complete:	Y	
Consultant Hired:		Ν	Event	Close	d by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action:

MD2

- 1 PERSONNEL REPRIMANDED
- 2 PERSONNEL RECEIVED ADDITIONAL TRAINING
- 3 PROCEDURE MODIFIED

Patient Number: 1									
Patient Informed: Y	Date	Informed: 09/0	4/2008						
Given:									
Therapeutic Procedure	: SODIUM IODI	DE - D							
Organ:	THYROID								
Radiopharmaceutical:	SODIUM IODI	DE							
Radionuclide: I-131		Activity:	3.8	mCi	140.6 N	ИBq	Dose:	4940 rad	49.4 Gy
Intended:									
Diagnostic Study:	WHOLE BODY	BONE							
Radiopharmaceutical:	MDP/MEDROM	ATE/OSTEOLI	ΓE						
Radionuclide: TC-99	М	Activity:	30	mCi	1110 N	ИBq			
% Dose Exceeds Pres	cribed: NA	N							
% Dose is Less Than F	Prescribed: NA	λ							
Effect on Patient:									
Source of Radiation:									
MD2									
Source Number:	1								
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE R	ADIOPH	IARM	Radionucl	ide or '	Voltage (k	Vp/MeV): I-131	
Manufacturer:	NR				Activity:			0.0038 Ci	0.1406 GBq
Model Number:	NA								
Serial Number:	NA								
References:									
Reference Number:	Entry Date:	Retraction D	ate: C	Coder Initia	ls: Refe	erence	e Type:		
TX-I-8568	10/17/2008		[DCH	AGF	REEME	ENT STAT	E EVENT REPORT	
LTR081112	11/12/2008		F	RLS	NRC	C LETT	FER		
LTR090311	03/24/2009		[DCH	AGF	REEME	ENT STAT	E LETTER	
TX080032	09/29/2009		[DCH	AGF	REEME	ENT STAT	E EVENT REPORT	
TX-I-8568A	09/29/2009		[DCH	AGF	REEME	ENT STAT	E EVENT REPORT	

Narrative:

The Department of Veterans Affairs (VA) reported that three patients prescribed permanent implant prostate brachytherapy procedures at the VA Medical Center in Washington, DC, may have received D90 doses less than 80% of the prescribed doses. Each patient was prescribed a dose of 125 Gy (12,500 rad) using Pd-103 seeds. The treatments occurred on 12/4/2007, 3/5/2008, and 4/2/2008. These medical events were discovered on 9/24/2008 as a result of an ongoing review of the incident reported in NMED Item 080296. Subsequent reviews determined that the D90 doses were greater than 80% of the prescribed doses and that all three patients received adequate doses. The initially identified discrepancy in the D90 doses was due to post implant prostate edema. VA retracted the incident report on 12/2/2008.

Event Date:	-	Discovery Date:	09/24/2008	Report		
		Discovery Date:	0312412000	Report	Dale. 09/20	2000
Licensee/Reporting Party Inform		Pooiprooit "	NONE			
Agreement State Regulated: NO License Number: 03	3-23853-01VA	Reciprocity: Name:	DEPARTMENT O			
	3034325	City:	NORTH LITTLE F			
	3613	,	Zip Code: 72114			
Responsible NRC Region: 3	5015	State: AN	Zip Code. 72114			
Site of Event:						
Site Name: WASHINGTON						
State: DC						
Additional Involved Party:						
License Number: NA		Name:	NA			
NRC Docket Number: NA		City:	NA			
NRC Program Code: NA		State: NA	Zip Code: NA			
Responsible NRC Region: NA	4					
Other Information:						
NRC Reportable Event:	N	Abnormal O		N		
Agreement State Reportable Ev		Investigation		Y		
Atomic Energy Act Material:	Y		ord Complete:	Y		
Consultant Hired:	N	Event Close	d by Region/State	: Y		
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: NOT REPORTED Corrective Actions Information: Action Number: Corrective Act MD2 1 NOT REPOR Patient Information:	ction:					
Patient Number: 1	Data lufama di					
Patient Informed: U	Date Informed:					
Given:						
Therapeutic Procedure: BRACH						
Organ: PROST	TATE					
Radiopharmaceutical: NA				_		
Radionuclide: PD-103	Activity:	NR mCi	NR MBq	Dose:	10000 rad	100 Gy
Intended: Therapeutic Procedure: BRACH Organ: PROST Radiopharmaceutical: NA Radionuclide: PD-103		NR mCi	NR MBq	Dose:	12500 rad	125 Gy
% Dose Exceeds Prescribed: % Dose is Less Than Prescribe Effect on Patient:	NA d: 80					

Patient Number: 2 Patient Informed: U	D	ate Informed:						
Given:								
Therapeutic Procedure:	BRACHY. N	ANUAL IMPLANT						
	PROSTATE							
Radiopharmaceutical:	NA							
Radionuclide: PD-103		Activity:	NR mCi	NR MBq	Dose:	10125 rad	101.25 Gy	
Intended:								
Therapeutic Procedure:	BRACHY, N	ANUAL IMPLANT						
Organ:	PROSTATE							
Radiopharmaceutical:	NA							
Radionuclide: PD-103		Activity:	NR mCi	NR MBq	Dose:	12500 rad	125 Gy	
% Dose Exceeds Prescr	ibodi	NA						
% Dose is Less Than Pr		81						
Effect on Patient:	escribeu.	01						
Patient Number: 3								
Patient Informed: U	П	ate Informed:						
Given:								
Therapeutic Procedure:								
0	PROSTATE							
Radiopharmaceutical:	NA	•			-			
Radionuclide: PD-103		Activity:	NR mCi	NR MBq	Dose:	10250 rad	102.5 Gy	
Therapeutic Procedure: Organ: Radiopharmaceutical: Radionuclide: PD-103	PROSTATE		NR mCi	NR MBq	Dose:	12500 rad	125 Gy	
Radionuclide. PD-103		Activity.	NR IIG		Dose.	12500 Tau	125 Gy	
% Dose Exceeds Prescr	ibed:	NA						
% Dose is Less Than Pr	escribed:	82						
Effect on Patient:								
Source of Radiation: MD2								
Source Number:	1							
Source/Radioactive Mat	erial: SEAL	ED SOURCE BRAG	CHYTHERAPY	Radionuclide or	Voltage	(kVp/MeV): PD-103	}	
Manufacturer:	NR			Activity:		NR Ci	NR	GBq
Model Number:	NR							
Serial Number:	AGG	REGATE						
Source Number:	2							
Source/Radioactive Mat	erial: SEAL	ED SOURCE BRAG	CHYTHERAPY	Radionuclide or	Voltage	(kVp/MeV): PD-103	}	
Manufacturer:	NR			Activity:	Ū	NR Ci		GBq
Model Number:	NR							
Serial Number:	AGG	REGATE						
Source Number:	3							
Source/Radioactive Mat		ED SOURCE BRAG	CHYTHERAPY	Radionuclide or	Voltage	(kVp/MeV): PD-103	}	
Manufacturer:	NR			Activity:	voltago	NR Ci		GBq
Model Number:	NR							4
Serial Number:		REGATE						
References:								
Reference Number:	Entry Date	e: Retraction D	ate: Coder Init	ials: Reference	e Tvne:			
EN44524	10/02/2008		DCH	EVENT N		TION		
ML082880661	10/27/2008		RLS	LICENSE				
ML082880041	11/03/2008		RLS	LICENSE				
	11/03/2000	,	INCO	LICENSE		X 1		

_	ML082880717	11/03/2008		RLS	CONFIRMATORY ACTION LETTER
	ML082890402	11/03/2008		RLS	NRC NEWS ANNOUNCEMENT
	EN44524A	12/03/2008	12/02/2008	DCH	EVENT NOTIFICATION
	LTR081230	01/13/2009		DCH	NRC LETTER
	ML101440380	05/26/2010		RLS	INSPECTION REPORT
	ML101440380	05/26/2010		RLS	NRC LETTER
	LTR100603	06/09/2010		DCH	NRC LETTER
	ML101880329	07/20/2010		RLS	ENFORCEMENT CONFERENCE
	ML101880329	07/20/2010		RLS	NRC LETTER
	ML101970407	08/16/2010		RLS	LICENSEE REPORT
	ML102350127	08/24/2010		RLS	NOTICE OF VIOLATION
	ML102350127	08/24/2010		RLS	NRC LETTER
	ML102350261	08/24/2010		RLS	NRC NEWS ANNOUNCEMENT
	ML102300006	09/01/2010		RLS	NOTIFICATION OF SIGNIFICANT ENFORCEMENT ACTION
	ML102430195	09/01/2010		RLS	LICENSEE REPORT

Narrative:

The Texas Department of State Health (DSH) initially reported that Texas Oncology PA Klabzuba (TOPAK) was cited for not having a current calibration for their Sr-90 eye applicator (Amersham model SIA.20, serial #0964ML). The applicator contained an original activity of 19.68 GBq (53.2 mCi). DSH based their citing on a new cal bration methodology developed by the National Institute of Standards and Testing (NIST). The DSH determined that the absorbed dose rate from the eye applicator, using the new cal bration methodology, was 56 cGy/second (rad/second), some 54% higher than what had been provided by the manufacturer. Although that absorbed dose rate was considerably different, the authorized physician user stated that the therapeutic response to the patients with the treatment device was acceptable. TOPAK received the applicator prior to NIST's reevaluation and changes to the calibration of Sr-90 eye applicators. When manufactured, the TOPAK source was calibrated according to the procedures available at that time. TOPAK used that calibrated activity value and decay corrections to determine the time needed to deliver a specific dose to the patients. The authorized physician user was getting expected results and the written directive included a standard dose to the patient. The three patients were prescribed two 1,500 cGy (rad) fractions separated by one week. Because the three patients received their treatments as prescribed on their written directives, the NRC concluded that no medical events occurred.

Event Dat	t e: 0	8/19/2008	Discovery I	Date:	08/19/2008	Report Date:	08/19/2008
Licensee/Reporting Party Inf	ormati	on:					
Agreement State Regulated:	YS		Recipro	ocity:	NONE		
License Number:	TX-L0	5545	Name:		TEXAS ONCOLOG	BY PA KLABZUBA	
NRC Docket Number:	NA		City:		FORT WORTH		
NRC Program Code:	NA		State:	ТΧ	Zip Code: 76104		
Responsible NRC Region:	4						
Site of Event:							
Site Name: FORT WORTH							
State: TX							
Additional Involved Party:							
License Number:	NA		Name:		NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State:	NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abnorn	nal O	ccurrence:	Ν	
Agreement State Reportable	Event:	Ν	Investi	gatior	1:	Y	
Atomic Energy Act Material:		Y	NMED	Reco	rd Complete:	Y	
Consultant Hired:		Ν	Event	Close	d by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: OTHER

Corrective Actions Information:

Action Number: Corrective Action:

MD2

NO CORRECTIVE ACTION TAKEN

Patient Number: 1 Patient Informed: U		Date Informed:					
Given:							
Therapeutic Procedure:	BRACHY	, EYE APPLICATOR					
Organ:	EYE						
Radiopharmaceutical:	NA						
Radionuclide: SR-90		Activity:	53.2 mCi	1968.4 MBq	Dose:	3000 rad	30 Gy
Intended:							
Therapeutic Procedure:	BRACHY	, EYE APPLICATOR					
Organ:	EYE						
Radiopharmaceutical:	NA						
Radionuclide: SR-90		Activity:	53.2 mCi	1968.4 MBq	Dose:	3000 rad	30 Gy
% Dose Exceeds Presc	ribed:	NA					
% Dose is Less Than P	rescribed:	NA					
Effect on Patient:							
Patient Number: 2							
Patient Informed: U		Date Informed:					
Given:							
Therapeutic Procedure:	BRACHY	, EYE APPLICATOR					
Organ:	EYE						
Radiopharmaceutical:	NA						
Radionuclide: SR-90		Activity:	53.2 mCi	1968.4 MBq	Dose:	3000 rad	30 Gy
Intended:							
Therapeutic Procedure:	BRACHY	, EYE APPLICATOR					
Organ:	EYE						
Radiopharmaceutical:	NA						
Radionuclide: SR-90		Activity:	53.2 mCi	1968.4 MBq	Dose:	3000 rad	30 Gy
% Dose Exceeds Presc	ribed:	NA					
% Dose is Less Than P	rescribed:	NA					
Effect on Patient:							
Patient Number: 3							
Patient Informed: U		Date Informed:					
Given:							
Therapeutic Procedure:	BRACHY	, EYE APPLICATOR					
Organ:	EYE						
Radiopharmaceutical:	NA						
Radionuclide: SR-90		Activity:	53.2 mCi	1968.4 MBq	Dose:	3000 rad	30 Gy
Intended:							
Therapeutic Procedure:	BRACHY	, EYE APPLICATOR					
Organ:	EYE						
Radiopharmaceutical:	NA						
Radionuclide: SR-90		Activity:	53.2 mCi	1968.4 MBq	Dose:	3000 rad	30 Gy
% Dose Exceeds Presc	ribed:	NA					
% Dose is Less Than P	rescribed:	NA					
Effect on Patient:							
ource of Radiation:							
ID2							

Source Number:	1								
Source/Radioactive	Material:	SEALED	SOURCE BRACH	IYTHERAPY	Radionuclide or Voltage (kVp/MeV): SR-90				
Manufacturer:		NR			Activity:		0.0532 Ci	1.9684 GBq	
Model Number:		NR							
Serial Number:		NR							
Device/Associated Equipment:									
MD2									
Device Number:	1								
Device Name:	EYE APF	LICATOR			Model N	umber:	SIA.20		
Manufacturer:	AMERSH	IAM			Serial Nu	umber:	0964ML		
References:									
Reference Numbe	r: Entr	y Date:	Retraction Date	e: Coder Initia	als: Re	ference Type:			
EN44426	08/2	8/2008		DCH		ENT NOTIFICA	TION REPORTED F .TE	ROM AN	

DCH

DCH

DCH

DCH

DCH

AGREEMENT STATE EVENT REPORT

AGREEMENT STATE LETTER

AGREEMENT STATE LETTER

AGREEMENT STATE LETTER

NRC LETTER

TX-I-8539

LTR081103

LTR081105

LTR081211

LTR090402

08/28/2008

11/05/2008

11/05/2008

12/15/2008

04/02/2009

Narrative:

Memorial Hospital reported that a patient was injected with 0.9 GBq (24.3 mCi) of Tc-99m sestamibi for a cardiac scan instead of intended dose of Tc-99m medronate for a whole body bone scan. The error was not discovered until the patient returned three hours later for scanning and it was observed that the radionuclide was not properly tagged. The patient was informed as well as the department manager and the radiologist. The patient will return on 7/21/2008 for the proper study. The highest organ exposure was the upper large intestine wall at 4.32 cGy (rad). The technician involved has been reinstructed on the extreme importance of checking all the labels prior to preparing and administering any radiopharmaceutical.

administering any radiophar	maceutical.				
Event Dat	te: 07/18/2008	Discovery Date:	07/18/2008	Report Date:	07/28/2008
Licensee/Reporting Party Inf	formation:				
Agreement State Regulated:	NO	Reciprocity:	NONE		
License Number:	49-10982-02	Name:	MEMORIAL HOS	SPITAL OF SHERID	AN COUNTY
NRC Docket Number:	03013772	City:	SHERIDAN		
NRC Program Code:	02120	State: WY	Zip Code: 82801	1	
Responsible NRC Region:	4				
Site of Event:					
Site Name: SHERIDAN					
State: WY					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	•	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:	N	Abaarraal		N	
NRC Reportable Event:	N Front N	Abnormal O		N	
Agreement State Reportable		Investigation		N	
Atomic Energy Act Material:			ord Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State	e: N	
Event Type:					
MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
Cause: HUMAN ERROF	R				
Corrective Actions Informati	ion:				
Action Number: Corrective	e Action:				
MD2					
1 PERSONI	NEL RECEIVED ADDITI	ONAL TRAINING			
Patient Information:					
Patient Number: 1					
Patient Informed: Y	Date Informed:				
	Date memori.				
Given:					
Diagnostic Study: CAF	RDIAC SCAN				
Radiopharmaceutical: SES	STAMIBI/CARDIOLITE				

Radionuclide: TC-99N	N	Activity:	24.3 mCi	899.1 MBq
Intended: Diagnostic Study:	BONE SCAN			
Radiopharmaceutical: Radionuclide: TC-99N	MEDRONATE M	Activity:	NR mCi	NR MBq

% Dose Exceeds Prescribed:NA% Dose is Less Than Prescribed:NAEffect on Patient:NA

Source of Radiation: MD2						
	1 erial: UNSEAL	ED SOURCE RADIO	PHARM Rac	lionuclide or Voltage (kVp/l	MeV): TC-99M	
Manufacturer: Model Number: Serial Number:	NR NA NA			vity:	0.0243 Ci	0.8991 GBq
References: Reference Number: EN44371	Entry Date: 07/31/2008	Retraction Date:	Coder Initials: DCH	Reference Type: EVENT NOTIFICATION		

Narrative:

Southern Regional Medical Center reported that a patient was administered 925 MBq (25 mCi) of Tc-99m MDP on 5/30/2008 for a bone scan. Approximately three hours later, the patient was inadvertently injected a second time with 740 MBq (20 mCi) of Tc-99m MDP.

Event Dat	te: (05/30/2008	Discovery Date:	05/30/2008	Report Date:	05/30/2008
Licensee/Reporting Party Inf	ormat	tion:				
Agreement State Regulated:	YS		Reciprocity:	NONE		
License Number:	GA-1	039-1	Name:	SOUTHERN REGI	ONAL MEDICAL C	CENTER
NRC Docket Number:	NA		City:	RIVERDALE		
NRC Program Code:	NA		State: GA	Zip Code: 30274		
Responsible NRC Region:	1					
Site of Event:						
Site Name: RIVERDALE						
State: GA						
Additional Involved Party:						
License Number:	NA		Name:	NA		
NRC Docket Number:	NA		City:	NA		
NRC Program Code:	NA		State: NA	Zip Code: NA		
Responsible NRC Region:	NA					
Other Information:						
NRC Reportable Event:		Ν	Abnormal O	ccurrence:	Ν	
Agreement State Reportable	Event	:: Y	Investigation	n:	Ν	
Atomic Energy Act Material:		Y	NMED Reco	ord Complete:	Y	
Consultant Hired:		Ν	Event Close	ed by Region/State:	Y	

740 MBq

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2 1 NOT REPORTED

Patient Information:

 Patient Number:
 1

 Patient Informed:
 U

 Date Informed:

Given:

Diagnostic Study: BONE SCAN

Radiopharmaceutical:MDP/MEDRONATE/OSTEOLITERadionuclide:TC-99MActivity:20 mCi

Intended:

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2

Source Number:	1				
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rac	lionuclide or Voltage (kVp/MeV): TC-99M	
Manufacturer:	NR		Acti	vity: 0.02 Ci	0.74 GBq
Model Number:	NA				
Serial Number:	NA				
References:					
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:	
GA-2008-20I	07/15/2008		DCH	AGREEMENT STATE EVENT REPORT	
LTR080715	07/15/2008		DCH	AGREEMENT STATE LETTER	

AGREEMENT STATE EVENT REPORT

DCH

GA-2008-20IA

09/17/2008

1	0
4	7

Narrative:

Saint Mary Medical Center reported that a patient prescribed to receive 0.93 GBq (25 mCi) of Tc-99m MDP for a bone scan received 0.85 GBq (23 mCi) of Tc-99m Sestamibi for a heart scan. The event occurred on 6/9/2008. The bone scan will be rescheduled. The cause of the incident was determined to be human error by the nuclear medicine technologist. Corrective actions included requiring that the technologist take a "time out" prior to each injection to review the dose to be administered, the dose ordered, and to fully and thoroughly check the markings in place on syringes and vials to prevent a recurrence. According to the manufacture's product insert, the patient could be expected to receive a maximum dose of 41.4 mGy (4.14 rad) to the upper large intestinal wall and a whole body dose of 3.83 mGy (383 mrad).

Event Dat	e: 0	6/09/2008	Discovery [Date:	06/09/2008	Report Date:	06/23/2008
Licensee/Reporting Party Inf	ormati	ion:					
Agreement State Regulated:	YS		Recipro	ocity:	NONE		
License Number:	WA-V	/N-M0101-1	Name:		SAINT MARY MED	DICAL CENTER	
NRC Docket Number:	NA		City:		WALLA WALLA		
NRC Program Code:	NA		State:	WA	Zip Code: NR		
Responsible NRC Region:	4						
Site of Event:							
Site Name: WALLA WALLA							
State: WA							
Additional Involved Party:							
License Number:	NA		Name:		NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State:	NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abnorn	nal O	ccurrence:	Ν	
Agreement State Reportable	Event:	Y	Investig	gatio	ו:	Ν	
Atomic Energy Act Material:		Y	NMED	Reco	ord Complete:	Y	
Consultant Hired:		Ν	Event (Close	d by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2 1 PERSONNEL REPRIMANDED

Defiered Nerroberts 4						
Patient Number: 1 Patient Informed: Y	Date Int	ormed.				
		onnou.				
Given:						
Diagnostic Study:	CARDIAC SCAN					
Radiopharmaceutical:	SESTAMIBI/CARI	DIOLITE				
Radionuclide: TC-99	M A	ctivity:	23 mCi	851 MBq		
Intended:						
Diagnostic Study:	BONE SCAN					
Radiopharmaceutical:	MDP/MEDRONAT	E/OSTEOLITE				
% Dose Exceeds Preso						
% Dose is Less Than P	rescribed: NA					
Effect on Patient:						
ource of Radiation:						
ID2						
Source Number:	1					
Source/Radioactive Ma		SOURCE RADIO			ge (kVp/MeV): TC-99M	
Manufacturer:	NR		1	Activity:	0.023 Ci	0.851 GBq
Model Number:	NA					
Serial Number:	NA					
eferences:						
Reference Number:	Entry Date: I	Retraction Date:	Coder Initial	s: Reference Typ	e:	
WA-08-037	07/02/2008		DCH	AGREEMENT	STATE EVENT REPORT	
EN44328	07/07/2008		DCH	EVENT NOTIF	ICATION REPORTED FRO	OM AN

Narrative:

Reid Hospital & Health Care Services reported that a patient prescr bed to receive a regular treadmill stress test instead received a treadmill myocardial perfusion imaging test using Tc-99m. The patient was administered 0.6 GBq (16.3 mCi) of Tc-99m for the resting portion of the test and 1.3 GBq (35.3 mCi) of Tc-99m for the stress portion of the test. Reid Hospital is conducting an investigation into the incident. They will inform the patient of the error. Reid Hospital retracted the incident on 5/21/2008, based on the fact that the error does not meet reporting requirements.

i e qui e i i e i i e i					
Event Date	e: 05/19/2008	Discovery Date:	05/19/2008	Report Date:	05/20/2008
icensee/Reporting Party Info	ormation:				
Agreement State Regulated:	NO	Reciprocity:	NONE		
License Number:	13-03284-02	Name:	REID HOSPITAL	& HEALTH CARE S	SERVICES
NRC Docket Number:	03001614	City:	RICHMOND		
NRC Program Code:	02230	State: IN	Zip Code: 47374		
Responsible NRC Region:	3				
Site of Event:					
Site Name: RICHMOND					
State: IN					
dditional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal O	ccurrence:	Ν	
Agreement State Reportable	Event: N	Investigation	ו:	Ν	
Atomic Energy Act Material:	Y	NMED Reco	ord Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State:	Y	

MD2 - MEDICAL EVENT Event Cause: MD2

Cause: NOT REPORTED

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Information:

Patient Number: 1

Patient Informed: N	Date Informed:
	Date momen.

Given:

Diagnostic Study: MYOCARDIAL PERFUSION

Radiopharmaceutical: MYOVIEW

Radionuclide: TC-99M

Intended:

A therapeutic procedure/diagnostic study was not intended.

Activity:

51.6 mCi

1909.2 MBq

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation:

MD2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Ra	dionuclide or Voltage (k)	/p/MeV): TC-99N	1
Manufacturer:	NR		Ac	tivity:	0.0516 Ci	1.9092 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
EN44224	05/27/2008	05/21/2008	DCH	EVENT NOTIFICATI	ON	
LTR080715	07/21/2008		DCH	NRC LETTER		

Narrative:

Baptist Hospital reported that a patient received an unprescribed dose of 0.19 GBq (5 mCi) of I-131 on 5/16/2008. The patient received a prescribed dose of 5.6 GBq (150 mCi) of I-131 on 5/9/2008. However, when the patient returned to the hospital on 5/16/2008 to receive a scan, the nuclear medicine technologist mistakenly administered the unprescribed dose of 0.19 GBq (5 mCi) of I-131. The patient and doctor have been notified of the event. The NRC Medical Radiation Safety Team investigated the incident and determined that it did not meet reportable criteria due to the fact that the patient's thyroid was ablated (totally removed). Therefore, the patient did not receive dose that meets the threshold reporting requirements.

Event Da	te: 05/16/2008	Discovery Date:	05/16/2008	Report Date:	05/16/2008
Licensee/Reporting Party Int Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region: Site of Event: Site Name: PENSACOLA State: FL		Reciprocity: Name: City: State: FL	NONE BAPTIST HOSPIT PENSACOLA Zip Code: 32501	AL	
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:	N Event: Y Y N			N Y Y Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROF					
Action Number: Corrective MD2 1 NOT REP	Action:				
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed: 05	5/16/2008			
0	DIUM IODIDE - T 'ROID DIUM IODIDE Activity:	5 mCi	185 MBq	Dose: NF	R rad NR Gy

Intended:

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient:

Source of Radiation:					
MD2					
Source Number:	1				
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM R	adionuclide or Voltage (kVp/Me)	V): I-131
Manufacturer:	NR		A	ctivity: 0	0.005 Ci 0.185 GBq
Model Number:	NA				
Serial Number:	NA				
References:					
Reference Number:	Entry Date:	Retraction Date:	Coder Initials	: Reference Type:	
EN44222	05/27/2008		DCH	EVENT NOTIFICATION RE AGREEMENT STATE	EPORTED FROM AN
LTR080625	06/26/2008		DCH	NRC LETTER	
FL08-079	07/25/2008		DCH	AGREEMENT STATE EVE	NT REPORT

Narrative:

Saint Thomas Hospital reported that a patient, scheduled to receive 0.19 GBq (5 mCi) of Tc-99m cholotec, was administered 0.79 GBq (21.4 mCi) of Tc-99m MDP on 5/18/2007. The pharmacist drew the MDP dosage and placed the cholotec label on the syringe. The nuclear medicine student did not properly assay the dosage prior to administration. Corrective actions included instituting new procedures to prevent recurrence.

recurrence.	phonic administration. Confective actions included instituting new procedures to	JIEVEIIL
Event Date: 05/18/2007	Discovery Date: 05/18/2007 Report Date: 05/30/2007	
Licensee/Reporting Party Information:		
Agreement State Regulated: YS	Reciprocity: NONE	
License Number: TN-R-19001-B98	Name: SAINT THOMAS HOSPITAL	
NRC Docket Number: NA	City: NASHVILLE	
NRC Program Code: NA	State: TN Zip Code: 37202	
Responsible NRC Region: 1		
Site of Event:		
Site Name: NASHVILLE		
State: TN		
Additional Involved Party: License Number: NR	Name: NR	
	- 9	
NRC Program Code: NR	State: NR Zip Code: NR	
Responsible NRC Region: NR		
Other Information:		
NRC Reportable Event: N	Abnormal Occurrence: N	
Agreement State Reportable Event: Y	Investigation: N	
Atomic Energy Act Material: Y	NMED Record Complete: Y	
Consultant Hired: N	Event Closed by Region/State: Y	
MD2 Cause: HUMAN ERROR Corrective Actions Information: Action Number: Corrective Action: MD2 1 NEW PROCEDURE WRITTEN		
Patient Information:		
Patient Number: 1		
Patient Informed: U Date Informed:		
Fatient morned. O Date morned.		
Given:		
Diagnostic Study: BONE SCAN		
Radiopharmaceutical: MDP/MEDRONATE/OSTEC		
Radionuclide: TC-99M Activity:	21.4 mCi 791.8 MBq	
Intended:		
Diagnostic Study: HEPATOBILIARY		
Radiopharmaceutical: MEBROFENIN/CHOLETEC	Н	
% Dose Exceeds Prescribed: NA		
% Dose is Less Than Prescribed: NA		
Effect on Patient:		
Source of Padiation		

Source Number:	1							
Source/Radioactive	e Material:	UNSEALED S	OURCE RADIOF	PHARM	Radionuc	lide or Voltage	(kVp/MeV): TC-	-99M
Manufacturer:		NR			Activity:		0.0214 Ci	0.7918 GBq
Model Number:		NA						
Serial Number:		NA						
Device/Associated	Equipmen	t:						
MD2								
Device Number:	1							
Device Name:	SYRING	E			Model Nu	mber:	NA	
Manufacturer:	NR				Serial Nur	mber:	NA	
References:								
Reference Numbe TN07101		ry Date: Ref 6/2008	traction Date:	Coder Initia DCH		erence Type: REEMENT STA	ATE EVENT REP	ORT

Narrative:

Saint Mary's Medical Center reported that a patient, not scheduled for a radioactive material test, was administered 1.48 GBq (40 mCi) of Tc-99m sestamibi on 3/30/2007. It was determined that the technologist did not verify the appropriate doctor's orders prior to proceeding with the test. The patient was scheduled in the electronic scheduling system; however, the doctor's order was for the previous year. The patient was under the impression that the doctor wanted him to schedule a stress test as well as some other blood work. When the patient requested to schedule the stress test and blood work, the scheduler saw the old order for 2006 and misinterpreted it. The patient and physician were notified of the incident. Corrective actions included generating a new procedure.

Event Date	e: 03	8/30/2007	Discovery Date	03/30/2007	Report Date:	04/03/2007
Licensee/Reporting Party Info	ormatio	on:				
Agreement State Regulated:	YS		Reciprocity	NONE		
License Number:	TN-R-4	17010	Name:	SAINT MARY'S M	IEDICAL CENTER,	INC.
NRC Docket Number:	NA		City:	KNOXVILLE		
NRC Program Code:	NA		State: TN	Zip Code: 37917		
Responsible NRC Region:	1					
Site of Event:						
Site Name: KNOXVILLE						
State: TN						
Additional Involved Party:						
License Number:	NA		Name:	NA		
NRC Docket Number:	NA		City:	NA		
NRC Program Code:	NA		State: NA	Zip Code: NA		
Responsible NRC Region:	NA					
Other Information:						
NRC Reportable Event:		Ν	Abnormal C	Occurrence:	Ν	
Agreement State Reportable E	Event:	Y	Investigatio	n:	Ν	
Atomic Energy Act Material:		Υ	NMED Rec	ord Complete:	Y	
Consultant Hired:		Ν	Event Close	ed by Region/State	: Y	

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NEW PROCEDURE WRITTEN

Patient Information:

Patient Number: 1

Patient Informed: Y Date Informed: 03/30/2007

Given:

Diagnostic Study: CARDIAC PERFUSION

Radiopharmac	eutical:	SESTAMIBI/CARDIOLITE		
Radionuclide:	TC-99N	Activity:	40 mCi	1480 MBq

Intended:

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed:NA% Dose is Less Than Prescribed:NAEffect on Patient:

Source of Radiation: MD2						
Source Number: Source/Radioactive Mat	1 erial: UNSEAL	ED SOURCE RADIO	PHARM Ra	dionuclide or Voltage (kVp/Me	V): TC-99M	
Manufacturer: Model Number: Serial Number:	NR NA NA		Act	ivity:	0.04 Ci	1.48 GBq
References: Reference Number: TN07070	Entry Date: 04/16/2008	Retraction Date:	Coder Initials: DCH	Reference Type: AGREEMENT STATE EVE	ENT REPORT	

Narrative:

Saint Mary's Medical Center reported that a patient scheduled for a non-radioactive material stress test was administered 0.41 GBq (11.2 mCi) of Tc-99m myoview on 2/17/2007. It was determined that the technologist quickly looked at the order, but failed to notice the test prescribed. The patient, physician, and RSO were notified of the incident. Corrective actions included providing additional training to the technologist.

technologist.					
Event Date:	02/17/2007 Disc	covery Date:	02/17/2007	Report Date:	02/20/2007
Licensee/Reporting Party Inform	nation:				
Agreement State Regulated: YS		Reciprocity:	NONE		
License Number: TN	-R-47010	Name:	SAINT MARY'S ME	EDICAL CENTER,	INC.
NRC Docket Number: NA	L .	City:	KNOXVILLE		
NRC Program Code: NA	L Contraction of the second seco	State: TN	Zip Code: 37917		
Responsible NRC Region: 1					
Site of Event:					
Site Name: KNOXVILLE					
State: TN					
Additional Involved Party:					
License Number: NA	L Contraction of the second seco	Name:	NA		
NRC Docket Number: NA	L Contraction of the second seco	City:	NA		
NRC Program Code: NA		State: NA	Zip Code: NA		
Responsible NRC Region: NA	L Contraction of the second				
Other Information:					
NRC Reportable Event:	Ν	Abnormal O	ccurrence:	Ν	
Agreement State Reportable Eve	ent: Y	Investigation		Y	
Atomic Energy Act Material:	Y		ord Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State:	Y	
Event Type:					
MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
Cause: HUMAN ERROR					
Corrective Actions Information:					
Action Number: Corrective Act	tion:				
MD2					
1 PERSONNEL	RECEIVE NEW TRAINING	1			
Patient Information:					
Patient Number: 1					
Patient Informed: Y	Date Informed: 02/17/20	07			
Given:					
Diagnostic Study: CARDIA	AC SCAN				
, ,					
Radiopharmaceutical: MYOVI	EW				
Radionuclide: TC-99M	Activity: 1	1.2 mCi	414.4 MBq		

Intended:

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2

Source Number:	1					
Source/Radioactive Ma	terial: UNSEAL	ED SOURCE RADIO	PHARM F	Radionuclide or Volta	ge (kVp/MeV): TC-99M	l
Manufacturer:	NR		A	Activity:	0.0112 Ci	0.4144 GBq
Model Number:	NA					
Serial Number:	NA					
eferences:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initial	s: Reference Typ	e:	
TN07026	04/15/2008		DCH	AGREEMENT	STATE EVENT REPORT	

Narrative:

Saint Mary's Medical Center reported that a patient was mistakenly administered a second dose of Tc-99m when the appropriate dose had already been administered. On 1/22/2007, the patient was administered 0.74 GBq (20 mCi) of Tc-99m HDP at the North complex for a bone scan. The patient was then instructed to go to Saint Mary's main campus for a CT scan and return to the North complex to complete the bone scan. However, when the technician at the main campus saw the physician's order, which included the bone scan, she instructed the Nuclear Medicine Department to administer a bone scan. The technician injected the patient with 1.01 GBq (27.2 mCi) of Tc-99m HDP, not realizing that the patient had already received 0.74 GBq (20 mCi). The physician and patient were notified of the error. A new policy was developed and instituted. The root cause appears to be the temporary occurrence of having one facility that was not fully operational.

Event Dat	t e: 0	1/22/2007	Disc	overy Date:	01/22/2007	Report Date:	01/22/2007
Licensee/Reporting Party Inf	ormati	on:					
Agreement State Regulated:	YS			Reciprocity:	NONE		
License Number:	TN-R-	47010		Name:	SAINT MARY'S ME	EDICAL CENTER, I	NC.
NRC Docket Number:	NA			City:	KNOXVILLE		
NRC Program Code:	NA			State: TN	Zip Code: 37917		
Responsible NRC Region:	1						
Site of Event:							
Site Name: KNOXVILLE							
State: TN							
Additional Involved Party:							
License Number:	NA			Name:	NA		
NRC Docket Number:	NA			City:	NA		
NRC Program Code:	NA			State: NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν		Abnormal O	ccurrence:	Ν	
Agreement State Reportable	Event:	Y		Investigation	า:	Y	
Atomic Energy Act Material:		Y		NMED Reco	ord Complete:	Y	
Consultant Hired:		Ν		Event Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION TO DETAIL

Corrective Actions Information:

Action Number: Corrective Action: MD2 1 NEW PROCEDURE WRITTEN

Patient Informed: Y Date Informed: 01/22/2007 Given: Diagnostic Study: BONE SCAN Radiopharmaceutical: HYDROXYMETHYLENE DIPHOSPHONATE Herain and the second sec	Patient Number: 1					
Diagnostic Study: BONE SCAN Radiopharmaceutical: HYDROXYMETHYLENE DIPHOSPHONATE Radionuclide: TC-99M Activity: 27.2 mCi 1006.4 MBq Intended: A therapeutic procedure/diagnostic study was not intended. % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR % Activity: 0.0272 Ci 1.0064 GBq Model Number: NA % Serial Numb		Date	Informed: 01/22/20	07		
Radiopharmaceutical: HYDROXYMETHYLENE DIPHOSPHONATE Radionuclide: TC-99M Activity: 27.2 mCi 1006.4 MBq Intended: A therapeutic procedure/diagnostic study was not intended. % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: bource of Radiation: MD2 Source Number: 1 Source Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Given:					
Radionuclide: TC-99M Activity: 27.2 mCi 1006.4 MBq Intended: A A therapeutic procedure/diagnostic study was not intended. % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: 0.0272 Ci 1.0064 GBq Model Number: NA Serial Number: NA References: Reference Number: Retraction Date: Coder Initials: Reference Type:	Diagnostic Study:	BONE SCAN				
Intended: A therapeutic procedure/diagnostic study was not intended. % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: AD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: 0.0272 Ci 1.0064 GBq Model Number: NA Serial Number: NA Serial Number: NA References: References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Radiopharmaceutical:	HYDROXYMET	HYLENE DIPHOSP	HONATE		
A therapeutic procedure/diagnostic study was not intended. % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: 0.0272 Ci 1.0064 GBq Model Number: NA Serial Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Radionuclide: TC-99	Μ	Activity: 2	27.2 mCi 10	006.4 MBq	
% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: 0.0272 Ci 1.0064 GBq Model Number: NA Serial Number: NA Serial Number: NA	Intended:					
% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: 0.0272 Ci 1.0064 GBq Model Number: NA Serial Number: NA Serial Number: NA	A therapeutic procedur	e/diagnostic stud	y was not intended.			
MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: 0.0272 Ci 1.0064 GBq Model Number: NA Serial Number: NA References: References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	% Dose is Less Than F Effect on Patient:					
Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: 0.0272 Ci 1.0064 GBq Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Reference Number: Entry Date: Coder Initials: Reference Number: Entry Date: Coder Initials: Reference Type:						
Manufacturer: NR Activity: 0.0272 Ci 1.0064 GBq Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:		1				
Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Number: Entry Date: Retraction Date:	Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	OPHARM Rad	dionuclide or Voltage (kVp/MeV): TC-99	Μ
Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Manufacturer:	NR		Act	ivity: 0.0272 Ci	1.0064 GBq
References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Model Number:	NA				
Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Serial Number:	NA				
	References:					
TN07022 03/17/2008 DCH AGREEMENT STATE EVENT REPORT	Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:	
	TN07022	03/17/2008		DCH	AGREEMENT STATE EVENT REPOR	RT

Narrative:

Middle Tennessee Medical Center reported administering 185 MBq (5 mCi) of Tc-99m choletec to a patient on 1/10/2007 that was not prescribed a nuclear medicine test. The technician glanced through the patient's chart and saw an order that appeared to be a hepatobiliary scan. After the patient was injected and placed over the camera for imaging, the technician reviewed the chart again and discovered the order was not for a hepatobiliary scan. The patient, RSO, and referring physician were notified of the error. The technician was counseled about reviewing a patient's chart completely prior to injection.

Event Dat	e:	01/10/2007	Discovery Date:	01/10/2007	Report Date:	01/19/2007
icensee/Reporting Party Infe	orma	tion:				
Agreement State Regulated:	YS		Reciprocity:	NONE		
License Number:	TN-F	R-75099	Name:	MIDDLE TENNES	SEE MEDICAL CE	NTER
NRC Docket Number:	NA		City:	MURFREESBORG)	
NRC Program Code:	NA		State: TN	Zip Code: NR		
Responsible NRC Region:	1					
ite of Event:						
Site Name: MURFREESBOR	RO					
State: TN						
Additional Involved Party:						
License Number:	NA		Name:	NA		
NRC Docket Number:	NA		City:	NA		
NRC Program Code:	NA		State: NA	Zip Code: NA		
Responsible NRC Region:	NA					
ther Information:						
NRC Reportable Event:		Ν	Abnormal O	ccurrence:	Ν	
Agreement State Reportable	Even	t: Y	Investigation	ו:	Ν	
Atomic Energy Act Material:		Y	NMED Reco	ord Complete:	Y	
Consultant Hired:		Ν	Event Close	d by Region/State:	Y	

MD2

Cause: INATTENTION TO DETAIL

Corrective Actions Information:

Action Number:	Corrective Action:
MD2	
1	PERSONNEL RECEIVED ADDITIONAL TRAINING
Patient Informatio	
Patient Number:	: 1

Patient Informed: Y	Date Informed: 01/1	0/2007	
Given: Diagnostic Study:	HEPATOBILIARY		
Radiopharmaceutical: Radionuclide: TC-99	MEBROFENIN/CHOLETECH M Activity:	5 mCi	185 MBq

Intended:

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation:

MD2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Radi	onuclide or Voltage (kVp/MeV):	: TC-99M	
Manufacturer:	NR		Activ	ity: 0.0	05 Ci 0.185 GB	q
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number: TN07015	Entry Date: 03/17/2008	Retraction Date:	Coder Initials: DCH	Reference Type: AGREEMENT STATE EVENT	T REPORT	

Narrative:

Saint Mary's Medical Center reported that a wrong patient (an 88-year-old female) patient was injected with 0.15 GBq (4.1 mCi) of Tc-99m cholotec on 11/15/2006. The patient was not scheduled for any diagnostic study. The technologist entered the room, but did not check the patient's bracelet. The technologist received inservice training and a new policy was instituted to prevent recurrence.

Event Dat	te: 11/15/2006	Discovery Date:	11/15/2006	Report Date:	12/29/2006
Licensee/Reporting Party Inf	ormation:				
Agreement State Regulated:	YS	Reciprocity:	NONE		
License Number:	TN-R-07003	Name:	SAINT MARY'S M	EDICAL CENTER	FO CAMPBELL COUNTY
NRC Docket Number:	NA	City:	LA FOLLETTE		
NRC Program Code:	NA	State: TN	Zip Code: 37766		
Responsible NRC Region:	1				
Site of Event:					
Site Name: LA FOLLETTE					
State: TN					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal C	ccurrence:	Ν	
Agreement State Reportable	Event: Y	Investigation	n:	Y	
Atomic Energy Act Material:	Y	NMED Reco	ord Complete:	Y	
Consultant Hired:	Ν	Event Close	ed by Region/State:	Y	
Event Type:					
MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
Cause: HUMAN ERROF	र				
Corrective Actions Information	on:				
Action Number: Corrective	Action:				
MD2					
MD2 1 NEW PRC	OCEDURE WRITTEN NEL RECEIVED ADDITI				

Patient Information:

Patient Number: 1 Patient Informed: Y	Date Informed: 11/15/2006
Given: Diagnostic Study:	NR
Radiopharmaceutical:	MEBROFENIN/CHOLETECH

Radionuclide:	TC-99M	Activity:	4.1 mCi	151.7 MBq
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Intended:

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2

Source Number: 1						
Source/Radioactive Materia	al: UNSEAL	ED SOURCE RADIO	PHARM Rad	ionuclide or Voltage (kVp/I	MeV): TC-99M	
Manufacturer:	NR		Activ	vity:	0.0041 Ci	0.1517 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number: E	ntry Date:	Retraction Date:	Coder Initials:	Reference Type:		
TN06159 02	2/28/2008		DCH	AGREEMENT STATE E	VENT REPORT	

Narrative:

Vanderbilt University reported that the wrong patient received 0.38 GBq (10.2 mCi) of straight Tc-99m for a thyroid study on 11/7/2006. The patient was prescribed to receive a diagnostic dosage containing 0.48 GBq (13 mCi) of Tc-99m myoview for a cardiac scan. Both dosages were stored behind the L-block in the hot laboratory. A student technologist identified the patient for the heart study, but mistakenly took the Tc-99m thyroid study dosage and injected the patient. She notified the senior technologist of the error. The physician was contacted and advised the technicians to administer the myoview dosage to complete the cardiac scan. The patient was notified of the incident. The patient's EDE was calculated as 4.81 mSv (481 mrem) and the highest organ dose was estimated to be 2.11 cSv (rem) to the ULI. Corrective actions included additional training to personnel.

Event Da	te: 1	1/07/2006	Discovery Dat	te:	11/07/2006	Report Date:	11/08/2006
Licensee/Reporting Party In	formati	on:					
Agreement State Regulated:	YS		Reciproci	ty: I	NONE		
License Number:	TN-R-	19021	Name:	١	ANDERBILT UNI	VERSITY	
NRC Docket Number:	NA		City:	1	NASHVILLE		
NRC Program Code:	NA		State: TI	N Z	Zip Code: 37232		
Responsible NRC Region:	1						
Site of Event:							
Site Name: NASHVILLE							
State: TN							
Additional Involved Party:							
License Number:	NA		Name:	1	NA		
NRC Docket Number:	NA		City:	1	NA		
NRC Program Code:	NA		State: N	A Z	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abnormal	l Oc	currence:	N	
Agreement State Reportable	e Event:	Y	Investigat	tion:		Ν	
Atomic Energy Act Material:		Y	NMED Re	ecor	d Complete:	Y	
Consultant Hired:		Ν	Event Clo	sed	by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2 1 PERSONNEL RECEIVED ADDITIONAL TRAINING

Patient Number: 1	5 / 1	<pre>c</pre>					
Patient Informed: Y	Date In	nformed: 11/07/2	006				
Given:							
Diagnostic Study:	THYROID IMAGI	ING					
Radiopharmaceutical:	NA						
Radionuclide: TC-99N	A N	Activity:	10.2 mCi	377.4 MBq			
Intended:							
Diagnostic Study:	CARDIAC SCAN						
Radiopharmaceutical:	MYOVIEW						
% Dose Exceeds Preso	cribed: NA						
% Dose is Less Than P	Prescribed: NA						
Effect on Patient:							
ource of Radiation:							
ID2							
Source Number:	1						
Source/Radioactive Ma		D SOURCE RAD	IOPHARM		Voltage (kVp/MeV)		
Manufacturer:	NR			Activity:	0.01	02 Ci	0.3774 GBq
Model Number:	NA						
Serial Number:	NA						
References:							
Reference Number:	Entry Date:	Retraction Date	: Coder Initi	als: Referenc	e Type:		
TN06137	02/28/2008		DCH		ENT STATE EVEN	T REPORT	

Narrative:

Middle Tennessee Medical Center reported that the wrong patient received 0.74 GBq (20 mCi) of Tc-99m MDP for a bone scan. The technologist checked the patient's arm band, noted the correct first and last names, and administered the Tc-99m. The technologist then looked at the patient's chart for additional information and discovered the mistake. The technologist notified the operations manager and the nurse, but did not notify the RSO. The RSO learned of the incident two months later. It was determined that the technologist failed to follow procedures regarding two methods of identifying patients. The Radiation Safety Committee developed procedures to assure the RSO is notified.

Event Dat	e: 07	/18/2006	Disco	overy Date	e:	07/18/2006	Repo	ort Date:	09/29/2006
Licensee/Reporting Party Infe	ormatio	n:							
Agreement State Regulated:	YS		F	Reciprocit	y: N	IONE			
License Number:	TN-R-7	5009-B99	1	Name:	N	11DDLE TENNES	SEE ME	EDICAL CEN	TER
NRC Docket Number:	NA		(City:	N	IURFREESBORC)		
NRC Program Code:	NA		9	State: TN	ΙZ	ip Code: 37133			
Responsible NRC Region:	1								
Site of Event:									
Site Name: MURFREESBOR	RO								
State: TN									
Additional Involved Party:									
License Number:	NA		1	Name:	Ν	IA			
NRC Docket Number:	NA		(City:	Ν	IA			
NRC Program Code:	NA		9	State: NA	λZ	ip Code: NA			
Responsible NRC Region:	NA								
Other Information:									
NRC Reportable Event:		N	/	Abnormal	Occ	currence:	Ν		
Agreement State Reportable	Event:	Y	I	Investigati	on:		Ν		
Atomic Energy Act Material:		Y	1	NMED Re	cord	d Complete:	Y		
Consultant Hired:		Ν	E	Event Clos	sed	by Region/State:	Y		

Event Type:

MD2 - MEDICAL EVENT

Event Cause:

MD2

Cause: FAILURE TO FOLLOW PROCEDURE OR WRONG PROCEDURE USED

Corrective Actions Information:

Action Number: Corrective Action:

MD2

1 NEW PROCEDURE WRITTEN

2 PERSONNEL RECEIVE IMPROVED SUPERVISION

Patient Number: 1						
Patient Informed: Y	Date	e Informed: 07/18/	2006			
Given:						
Diagnostic Study:	BONE SCAN					
Radiopharmaceutical:	MDP/MEDRO	NATE/OSTEOLITE				
Radionuclide: TC-99	Μ	Activity:	20 mCi	740 MBq		
Intended:						
A therapeutic procedur	e/diagnostic stud	dy was not intende	d.			
% Dose Exceeds Pres	cribed: NA	Ą				
% Dose Exceeds Pres % Dose is Less Than F Effect on Patient: ource of Radiation: ID2		-				
% Dose is Less Than F Effect on Patient: ource of Radiation:		-				
% Dose is Less Than F Effect on Patient: ource of Radiation: ID2	Prescribed: NA	Ą	DIOPHARM	Radionuclide or Voltage	(kVp/MeV): TC-99M	
% Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number:	Prescribed: NA	Ą	DIOPHARM	Radionuclide or Voltage Activity:	(kVp/MeV): TC-99M 0.02 Ci	0.74 GBq
% Dose is Less Than F Effect on Patient: ource of Radiation: D2 Source Number: Source/Radioactive Ma	Prescribed: NA 1 aterial: UNSEAL	Ą	DIOPHARM	•	,	0.74 GBq
% Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer:	rescribed: NA 1 aterial: UNSEAL NR	Ą	DIOPHARM	•	,	0.74 GBq
% Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number:	1 aterial: UNSEAL NR NA	Ą	DIOPHARM	•	,	0.74 GBq
% Dose is Less Than F Effect on Patient: ource of Radiation: ID2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number:	1 aterial: UNSEAL NR NA	Ą		Activity:	,	0.74 GBq

Narrative:

Vanderbilt University reported that the wrong patient received 18.5 MBq (0.5 mCi) of Tc-99m sulfur colloid for a gastric emptying study. The prescribed patient for the dosage did not show up at the pediatric nuclear medicine department and the dosage remained behind the shielded area in the hot laboratory. Later in the day, another patient, a two-year-old, arrived for a bone scan. A diagnostic dosage containing 220.15 MBq (5.95 mCi) of Tc-99m MDP was assayed and taken to the patient's room for injection. Difficulties were encountered with the access port for the injection. The dosage was returned to the shielded area in the hot laboratory. When the access port was ready, the technician mistakenly took the sulfur colloid dosage and injected the patient. The mistake was discovered and the physician advised administering the correct dosage. The MDP dosage was also administered to the patient. The total effective dose from both administrations was estimated to be 5.62 mSv (562 mrem).

Event Da	ite: 10/03/2006	Discovery Date:	10/03/2006	Report Date:	10/04/2006
Licensee/Reporting Party In	formation:				
Agreement State Regulated:	: YS	Reciprocity:	NONE		
License Number:	TN-A-01901	Name:	VANDERBILT UNI	VERSITY	
NRC Docket Number:	NA	City:	NASHVILLE		
NRC Program Code:	NA	State: TN	Zip Code: 27323		
Responsible NRC Region:	1				
Site of Event:					
Site Name: NASHVILLE					
State: TN					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal C	ccurrence:	Ν	
Agreement State Reportable	e Event: Y	Investigation	n:	Ν	
Atomic Energy Act Material:	Y	NMED Reco	ord Complete:	Y	
Consultant Hired:	Ν	Event Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Number: 1						
Patient Informed: U	Date	Informed:				
Given:						
Diagnostic Study:	GASTRIC EMP	TYING				
Radiopharmaceutical:	SULFUR COLL	OID				
Radionuclide: TC-99I	N	Activity:	0.5 mCi	18.5 MBq		
Intended:						
Diagnostic Study:	BONE SCAN					
Radiopharmaceutical:	MDP/MEDRON	ATE/OSTEOLIT	E			
% Dose Exceeds Preso						
% Dose is Less Than F Effect on Patient:	Prescribed: NA					
ource of Radiation:						
1D2						
Source Number:	1					
Source/Radioactive Ma	terial: UNSEAL	ED SOURCE R/	ADIOPHARM	Radionuclide or Volta	age (kVp/MeV): TC-99M	
Manufacturer:	NR			Activity:	0.0005 Ci	0.0185 GBq
Model Number:	NA					
Serial Number:	NA					
eferences:						
	Entry Date:	Retraction D	ate: Coder Ini	tials: Reference Ty	pe:	

Narrative:

The University of California Davis Medical Center (UCDMC) reported that a patient received two HDR cylinder gynecological treatment fractions of 600 cGy (rad) to 5 mm past the surface of the cylinder on 1/31/2007. The patient was prescribed two fractions of 600 cGy (rad) to the surface of the cylinder. UCDMC believes that the treatment form was filled out by a resident radiation oncologist and was signed by both the attending radiation oncologist and the resident oncologist. When the radiation oncologist typed the official written directive into the Information for Management, Planning, Analysis and Coordination System (IMPAC), her intention was to treat to the surface of the cylinder. However, the treatment was planned according to the written directive to 5 mm past the surface of the cylinder. The plan was checked and signed off by the treating physician prior to administration. The radiation oncologist changed the prescription in IMPAC to reflect the dose that was administered. The treating physician has notified both the referring physician and the patient.

Event Dat	e: 0	1/31/2008	Discov	very Date:	02/01/2008	Report Date:	02/01/2008
Licensee/Reporting Party Inf	ormati	on:					
Agreement State Regulated:	YS		R	eciprocity:	NONE		
License Number:	CA-13	34-34	N	ame:	UNIVERSITY OF (CALIFORNIA DAVIS	S MEDICAL CENTER
NRC Docket Number:	NA		С	ity:	SACRAMENTO		
NRC Program Code:	NA		St	tate: CA	Zip Code: 95817		
Responsible NRC Region:	4						
Site of Event: Site Name: SACRAMENTO State: CA							
Additional Involved Party: License Number:	NA		N	ame:	NA		
NRC Docket Number:	NA			ity:	NA		
NRC Program Code:	NA		St	tate: NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	A	bnormal O	ccurrence:	Ν	
Agreement State Reportable	Event:	Y	In	vestigatior	1:	Ν	
Atomic Energy Act Material:		Υ	Ν	MED Reco	ord Complete:	Y	
Consultant Hired:		N	E	vent Close	d by Region/State:	Ν	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Number:	1							
Patient Informed: `	(Date Inforr	ned: 02/01/200	08				
Given:								
Therapeutic Procee	dure: BRACI	HY, REMOTE	AFTERLOADE	R, HDR				
Organ:	VAGIN	A						
Radiopharmaceutio	al: NA							
Radionuclide: NF	R	Activ	vity:	NR mCi	NR MBq	Dose:	NR rad	NR Gy
Intended:								
Therapeutic Proce	dure: BRACI	HY, REMOTE	AFTERLOADE	R, HDR				
Organ:	VAGIN	A						
Radiopharmaceutio	al: NA							
Radionuclide: NF	R	Activ	vity:	NR mCi	NR MBq	Dose:	1200 rad	12 Gy
AD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number:	1 1	SEALED SOU NR NR NR	RCE BRACHY	THERAPY	Radionuclide or Activity:	Voltage (kVp/MeV): NR NR Ci	NR GBq
Device/Associated I	Equipment:							
Device Number:	1							
Device Name:	-	AFTERLOADE			Model Number:		NR	
Manufacturer:	NR				Serial Number:		NR	
References:								
eferences: Reference Numbe	r: Entry	Date: Ret	raction Date:	Coder Initia	als: Referenc	e Type:		
	r: Entry 02/08		raction Date:	Coder Initia DCH DCH		•••	TE EVENT REPOF	RT

Narrative:

The Department of Veterans Affairs (VA) reported a possible medical event involving the administration of 133.2 MBq (3.6 mCi) of F-18 FDG for a PET scan to a patient using the wrong route of administration. The incident occurred on 1/17/2007 at the VA Boston Healthcare system in West Roxbury, Massachusetts. During intravenous administration, a substantial portion of the radiopharmaceutical leaked from the injected vein and infiltrated much of the antecubital soft tissue adjacent to the left elbow. The leak was discovered during imaging one hour after the administration. Dose estimates to the tissue range from 0.2 to 96 cSv (rem). The referring physician and patient were notified. This event was caused by inaccurate placing of the intravenous needle in a very small vein. No adverse effects to the patient were observed. The incident was retracted on 3/12/2008 because infiltration is not considered to be a wrong route of administration.

Event Dat	e: 01/17/2008	Discovery Date:	01/17/2008	Report Date:	01/18/2008
Licensee/Reporting Party Inf	ormation:				
Agreement State Regulated:	NO	Reciprocity:	NONE		
License Number:	03-23853-01VA	Name:	DEPARTMENT O	F VETERANS AFF	AIRS
NRC Docket Number:	03034325	City:	NORTH LITTLE F	ROCK	
NRC Program Code:	03613	State: AR	Zip Code: 72114		
Responsible NRC Region:	3				
Site of Event:					
Site Name: WEST ROXBUR	RY				
State: MA					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal O	ccurrence:	Ν	
Agreement State Reportable	Event: N	Investigation	ו:	Ν	
Atomic Energy Act Material:	Y	NMED Reco	ord Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State	: Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2 1 NOT REPORTED

Patient Number: 1	Data	la fa ma a du 04/40/000	0			
Patient Informed: Y	Date	Informed: 01/18/200	8			
Given:						
Diagnostic Study:	PET SCAN					
Radiopharmaceutical:	FDG (FLUORO	DEOXYGLUCOSE)				
Radionuclide: F-18		Activity: 3	3.6 mCi 13	33.2 MBq		
Intended:						
Diagnostic Study:	PET SCAN					
Radiopharmaceutical:	FDG (FLUORO	DEOXYGLUCOSE)				
Radionuclide: F-18		Activity: 3	3.6 mCi 13	33.2 MBq		
Source of Radiation: MD2 Source Number: Source/Radioactive Ma Manufacturer: Model Number: Serial Number:	1 aterial: UNSEAL NR NA NA	ED SOURCE RADIO	PHARM Rad Activ	ionuclide or Voltage (kVp /ity:	/MeV): F-18 0.0036 Ci	0.1332 GBq
Keywords: MD2						
REVISED BYPRODUC	T MATERIAL DE	FINITION				
References:	Entry Data	Deter dian Deter		D. (
Reference Number: EN43917	Entry Date: 01/24/2008	Retraction Date: 03/12/2008	Coder Initials: DCH	Reference Type: EVENT NOTIFICATION	A.	
EN43917 EN43917A	03/13/2008	03/12/2008	DCH	EVENT NOTIFICATION		
LTR080409	04/14/2008	00,12/2000	DCH	NRC LETTER	•	
ML080310827	09/30/2009		RLS	LICENSEE REPORT		

Narrative:

Charlotte Hungerford Hospital reported that 0.26 GBq (7 mCi) of Tc-99m was administered to the wrong patient on 1/3/2008. A technologist went to a waiting room and called for a patient by their first name only. An older man answered and was taken to the radiology laboratory where a second technologist administered the Tc-99m. When the patient was taken to the radiologist, the error was noticed. The unintended patient had the same first name as the scheduled patient. The unintended patient was informed of the error. The intended patient was found and administered the prescribed dose. Charlotte Hungerford Hospital plans to perform better screening of patient (using first and last names, social security number, and date of birth by both technologists) to prevent recurrence.

	to: 0	1/03/2008	Discovery Date	01/03/2008	Report Date:	01/04/2008
Event Da			Discovery Date:	01/03/2000	Report Date:	01/04/2000
censee/Reporting Party In		on:				
greement State Regulated			Reciprocity			
cense Number:		349-04	Name:		INGERFORD HOSP	PITAL
NRC Docket Number:	03009		City:	TORRINGTON		
IRC Program Code:	02120		State: CT	Zip Code: 06790)	
esponsible NRC Region:	1					
of Event:						
te Name: TORRINGTON						
ate: CT						
litional Involved Party:						
icense Number:	NA		Name:	NA		
NRC Docket Number:	NA		City:	NA		
IRC Program Code:	NA		State: NA	Zip Code: NA		
esponsible NRC Region:	NA					
er Information:						
RC Reportable Event:		N	Abnormal C	occurrence:	Ν	
greement State Reportable	e Event:	N	Investigatio	n:	Ν	
tomic Energy Act Material:		Y	NMED Rec	ord Complete:	Y	
Consultant Hired:		N		ed by Region/State	o∙ N	

7 mCi

259 MBq

Action Number: Corrective Action: MD2

1 PROCEDURE MODIFIED

Patient Information:

 Patient Number:
 1

 Patient Informed:
 Y
 Date Informed:
 01/03/2008

Given:

Diagnostic Study: NR

Radiopharmaceutical: NR

Radionuclide: TC-99M Activity:

Intended:

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed:NA% Dose is Less Than Prescribed:NAEffect on Patient:

Source of Radiation:						
MD2						
Source Number: 1						
Source/Radioactive Materi	al: UNSEAL	ED SOURCE RADIO	PHARM F	Radionuclide or Voltage (kVp	/MeV): TC-99M	
Manufacturer:	NR		ŀ	Activity:	0.007 Ci	0.259 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
	ntry Date: 1/10/2008	Retraction Date:	Coder Initial DCH	s: Reference Type: EVENT NOTIFICATIO	N	

Narrative:

A medical facility reported administering the wrong radiopharmaceutical to a patient. They stated that Cardinal Health delivered a mislabeled dose to their facility, which was labeled as containing 0.19 GBq (5.1 mCi) of Tc-99m Mertiatide (Mag-3). The patient was prescribed to have received a renal scan on 11/19/2007, but imaging revealed accumulation of material in the liver and spleen, typical of Tc-99m Sulfur Colloid. The information was relayed to Cardinal Health by the medical facility. The State of Louisiana performed an investigation of the incident.

The information was relayed to Cardinal Healt	h by the medical facility. The State of Louisi	ana performed an ir	vestigation of the incident.
Event Date: 11/19/2007	Discovery Date: 11/19/2007	Report Date:	12/14/2007
Licensee/Reporting Party Information:			
Agreement State Regulated: YS	Reciprocity: NONE		
License Number: LA-5394-L01	Name: CARDINAL HEA	LTH 414	
NRC Docket Number: NA	City: BATON ROUGE		
NRC Program Code: NA	State: LA Zip Code: 70817	7	
Responsible NRC Region: 4			
Site of Event:			
Site Name: BATON ROUGE			
State: LA			
Additional Involved Party:			
License Number: NR	Name: NR		
NRC Docket Number: NR	City: NR		
NRC Program Code: NR	State: NR Zip Code: NR		
Responsible NRC Region: NR			
Other Information:			
NRC Reportable Event: N	Abnormal Occurrence:	Ν	
Agreement State Reportable Event: Y	Investigation:	Y	
Atomic Energy Act Material: Y	NMED Record Complete:	Y	
Consultant Hired: N	Event Closed by Region/State	e: Y	
Cause: HUMAN ERROR Corrective Actions Information: Action Number: Corrective Action: MD2 1 NOT REPORTED			
Patient Information:			
Patient Number: 1	ed: 11/19/2007		
Given:			
Diagnostic Study: LIVER			
Radiopharmaceutical: SULFUR COLLOID			
Radionuclide: TC-99M Activit	y: 5.1 mCi 188.7 MBq		
Intended:			
Diagnostic Study: RENAL-TUBULAR SE	CRETION (MAG3)		
Radiopharmaceutical: MAG3 (MERCAPTO A	CETYL TRIGLYCI		
% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient:			

Source of Radiation:

Source Number:	1							
Source/Radioactive	e Material:	UNSEALE	D SOURCE RAI	DIOPHARM	Radio	nuclide or Voltage	e (kVp/MeV): TC	-99M
Manufacturer:		CARDINA	L HEALTH		Activity	y:	0.0051 Ci	0.1887 GBq
Model Number:		NA						
Serial Number:		NA						
Device/Associated I	Equipment	t:						
MD2								
Device Number:	1							
Device Name:	SYRING	Ξ			Model	Number:	NA	
Manufacturer:	NR				Serial	Number:	NA	
References:								
Reference Numbe	er: Entr	y Date:	Retraction Dat	te: Coder Init	ials:	Reference Type:	:	
EN43841	12/2	0/2007		DCH		EVENT NOTIFIC AGREEMENT ST	ATION REPORTE	D FROM AN
LA070030	02/1	4/2008		DCH		AGREEMENT ST	TATE EVENT REP	ORT

Last Updated: 01/07/2010

Narrative:

Saint Joseph Health Center administered diagnostic dosages to three patients that differed from the prescribed dosages by more than 20%. On 8/7/2007 and 9/5/2007, two patients were administered 1.117 GBq (30.2 mCi) of Tc-99m Medronate for bone scans instead of the prescribed 0.925 GBq (25 mCi), a difference of 20.8%. On 10/9/2007, a patient was administered 1.125 GBq (30.4 mCi) of Tc-99m Medronate for a bone scan instead of the prescribed 0.925 GBq (25 mCi), a difference of 20.8% (25 mCi), a difference of 21.6%. Corrective actions included procedure changes to require that dosages be adjusted to within 20% of the prescribed amount, personnel training, and quarterly audits.

Event Dat	e: 08/07/2007	Discovery Date:	10/15/2007	Report Date:	10/15/2007
Licensee/Reporting Party Info	ormation:				
Agreement State Regulated:	NO	Reciprocity:	NONE		
License Number:	24-02704-01	Name:	SAINT JOSEPH HI	EALTH CENTER	
NRC Docket Number:	03002310	City:	KANSAS CITY		
NRC Program Code:	02120	State: MO	Zip Code: 64114		
Responsible NRC Region:	3				
Site of Event: Site Name: KANSAS CITY State: MO					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal C	ccurrence:	Ν	
Agreement State Reportable	Event: N	Investigation	n:	Y	
Atomic Energy Act Material:	Y	NMED Reco	ord Complete:	Y	
Consultant Hired:	Ν	Event Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT

Event Cause: MD2

Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action:

MD2

- 1 PROCEDURE MODIFIED
- 2 PERSONNEL RECEIVE IMPROVED SUPERVISION

3 PERSONNEL RECEIVED ADDITIONAL TRAINING

Patient Number: 1 Patient Informed: U	Date	Informed:			
Given:					
Diagnostic Study:	BONE SCAN				
Diagnostic Study.	BOINE SCAIN				
Radiopharmaceutical:	MEDRONATE				
Radionuclide: TC-99	M	Activity:	30.2 mCi	1117.4 MBq	
Intended:					
Diagnostic Study:	BONE SCAN				
Diagnostic Study.	DONE SCAN				
Radiopharmaceutical:	MEDRONATE				
% Dose Exceeds Pres	cribed: NA	A			
% Dose is Less Than F	Prescribed: NA	4			
Effect on Patient:					
Patient Number: 2					
Patient Informed: U	Date	Informed:			
Given:					
Diagnostic Study:	BONE SCAN				
Radiopharmaceutical:					
Radionuclide: TC-99		Activity:	30.2 mCi	1117.4 MBq	
Radionaciae. 10-33	IVI	Activity.	50.2 moi		
Intended:					
Diagnostic Study:	BONE SCAN				
Radiopharmaceutical:	MEDRONATE				
% Dose Exceeds Pres					
% Dose is Less Than F	Prescribed: NA	A			
Effect on Patient:					
Patient Number: 3					
Patient Informed: U	Date	Informed:			
Given:					
Diagnostic Study:	BONE SCAN				
Radiopharmaceutical:	MEDRONATE				
Radionuclide: TC-99		Activity:	30.4 mCi	1124.8 MBq	
		Activity.	30.4 mor		
Intended:					
Diagnostic Study:	BONE SCAN				
Radiopharmaceutical:	MEDRONATE				
% Dose Exceeds Pres	cribed: NA	A			
% Dose is Less Than F					
Effect on Patient:		-			
Fliect on Paneni					

Source Number: 1						
Source/Radioactive Mate	rial: UNSEAL	ED SOURCE RADIO	PHARM F	adionuclide or Voltage	e (kVp/MeV): TC-99M	
Manufacturer:	NR		A	ctivity:	0.0302 Ci	1.1174 GBq
Model Number:	NA					
Serial Number:	NA					
Source Number: 2	2					
Source/Radioactive Mate	rial: UNSEAL	ED SOURCE RADIO	PHARM F	adionuclide or Voltage	e (kVp/MeV): TC-99M	
Manufacturer:	NR		A	ctivity:	0.0302 Ci	1.1174 GBq
Model Number:	NA					
Serial Number:	NA					
Source Number: 3	6					
Source/Radioactive Mate	rial: UNSEAL	ED SOURCE RADIO	PHARM F	adionuclide or Voltage	e (kVp/MeV): TC-99M	
Manufacturer:	NR		A	ctivity:	0.0304 Ci	1.1248 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials	: Reference Type	:	
ML073040167	11/16/2007		RLS	INSPECTION RE	PORT	
LTR071121	11/26/2007		DCH	NRC LETTER		
ML100060294	01/07/2010		RLS	INSPECTION RE	PORT	

Narrative:

The University of Iowa Hospital reported that a patient intervened during a vaginal treatment using Ir-192 brachytherapy sources. The patient removed one of the needles containing sources from her body. The needle was found by a nurse approximately 30 minutes after it had been removed by the patient. The needle was located at the foot of the bed near the patient's right ankle. The doctor directed the nurse to place the needle into a lead pig. There were six Ir-192 sources in the needle with a total activity of 0.26 GBq (7 mCi). The estimated dose to the nurse's hand was 0.13 mSv (13 mrem). The nurse's whole body dosimeter was sent for processing. The estimated dose to the patient's ankle is between 5 to 165 cSv (rem). The patient was monitored for acute radiation signs to the exposed areas of the legs and ankles. No signs of skin reaction were noted as of 12/5/2007. The patient received the intended therapeutic dose. The University will continue to monitor the patient. The incident was retracted on 1/2/2008.

Event Da	te: 1	0/19/2007	Discovery	Date:	10/19/2007	Report Date:	10/19/2007
Licensee/Reporting Party In	formati	on:					
Agreement State Regulated:	YS		Recipr	ocity:	NONE		
License Number:	IA-37-	1-52-AAB	Name:		UNIVERSITY OF	IOWA	
NRC Docket Number:	NA		City:		IOWA CITY		
NRC Program Code:	NA		State:	IA	Zip Code: 52242		
Responsible NRC Region:	3						
Site of Event:							
Site Name: IOWA CITY							
State: IA							
Additional Involved Party:							
License Number:	NA		Name:		NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State:	NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abnori	mal O	ccurrence:	Ν	
Agreement State Reportable	e Event:	Y	Investi	gatio	n:	Ν	
Atomic Energy Act Material:		Y	NMED	Reco	ord Complete:	Y	
Consultant Hired:		Ν	Event	Close	ed by Region/State:	Υ	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: PATIENT INTERVENTION

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Number: 1 Patient Informed: U	Date	Informed:					
Given:							
Therapeutic Procedure:	BRACHY, MAN	UAL AFTERLOADE	ER				
Organ:	ANKLE						
Radiopharmaceutical:	NA						
Radionuclide: IR-192		Activity:	7 mCi	259 MBq	Dose:	165 rad	1.65 Gy
Intended:							
A therapeutic procedure	e/diagnostic stud	y was not intended.					
% Dose Exceeds Presc	ribed: 100)					
% Dose is Less Than P	rescribed: NA						
Effect on Patient:							
Patient Number: 1A							
Patient Informed: U	Date	Informed:					
Given:							
Therapeutic Procedure:	BRACHY, MAN	UAL AFTERLOADE	ER				
	VAGINA						
Radiopharmaceutical:	NA						
Radionuclide: IR-192		Activity:	7 mCi	259 MBq	Dose:	NR rad	NR Gy
Intended:							
Therapeutic Procedure:	BRACHY, MAN	IUAL AFTERLOADE	ER				
Organ:	VAGINA						
Radiopharmaceutical:	NA						
Radionuclide: IR-192		Activity:	7 mCi	259 MBq	Dose:	NR rad	NR Gy
% Dose Exceeds Presc	ribed: NA						
% Dose is Less Than P	rescribed: NR						
Effect on Patient:							
Source of Radiation:							
MD2							
Source Number:	1						
Source/Radioactive Mat		SOURCE BRACHY	THERAPY		Voltage (kV	p/MeV): IR-192	
Manufacturer:	NR			Activity:		0.007 Ci	0.259 GBq
Model Number:	NR						
Serial Number:	AGGREC	BATE					
Device/Associated Equip MD2	pment:						
Device Number: 1							
Device Name: API	PLICATOR			Model Number:	N	A	
Manufacturer: NR				Serial Number:	N	A	
References:							
Reference Number:	Entry Date:	Retraction Date:	: Coder Initia	als: Referenc	е Туре:		
EN43734	10/25/2007	01/02/2008	DCH			N REPORTED F	ROM AN
EN43734A	01/03/2008	01/02/2008	DCH		ENT STATE	N REPORTED F	
LIN4J/J4A	01/03/2000	01/02/2000			ENT STATE		
LTR080104	01/08/2008		DCH	AGREEM	ENT STATE	LETTER	

Narrative:

Cardinal Health reported that a customer contacted them regarding a Tc-99m mertiatide prescription for renal imaging that showed no renal distribution, but instead showed only liver distribution. Cardinal Health investigated the incident and determined that the error occurred in the pharmacy. The root cause was identified as procedures not followed. All customers affected by the incident were notified. Only one patient was injected. Corrective actions taken by Cardinal Health included retraining on policy and procedures regarding compounding doses.

was injected. Co	orrective actio		al Health included retra		Report Date:	
			Discovery Date:	09/24/2007	Report Date:	10/04/2007
Licensee/Reportin			Designed	NONE		
Agreement State	-		Reciprocity:		T 11	
		A-3385-L01	Name:	CARDINAL HEAI	_1H	
NRC Docket Nun		JA LA	City:	NEW ORLEANS		
NRC Program Co		NA .	State: LA	Zip Code: NR		
Responsible NR0	C Region: 4	ł				
Site of Event:						
Site Name: NEV	V ORLEANS					
State: LA						
Additional Involve	ed Party:					
License Number:	: N	NR .	Name:	NR		
NRC Docket Nun	mber: N	IR	City:	NR		
NRC Program Co	ode: N	IR	State: NR	Zip Code: NR		
Responsible NR0		IR				
Other Information	-					
NRC Reportable		Ν	Abnormal O	contrence.	N	
Agreement State			Investigation		N Y	
Atomic Energy A		Y	•	rd Complete:	Y	
Consultant Hired		N		d by Region/State		
Consultant Theu		IN	Lvent Close	u by Region/State	. 1	
Event Cause: MD2 Cause: FAIL	URE TO FOL	LOW PROCEDURE	OR WRONG PROCE	DURE USED		
MD2	s Informatior	1:	OR WRONG PROCE	DURE USED		
MD2 Cause: FAIL Corrective Action Action Number:	s Informatior	1:	E OR WRONG PROCE	DURE USED		
MD2 Cause: FAIL Corrective Action	is Informatior Corrective A	n: Action:	E OR WRONG PROCE	DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1	S Information Corrective A PERSONNE	n: Action:		DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information	S Information Corrective A PERSONNE	n: Action:		DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Number	S Information Corrective A PERSONNE Dn: :: 1	n: Notion: EL RECEIVED ADD		DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information	S Information Corrective A PERSONNE Dn: :: 1	n: Action:		DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Number	S Information Corrective A PERSONNE Dn: :: 1	n: Notion: EL RECEIVED ADD		DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Number Patient Informed	PERSONNE Corrective A PERSONNE DI 1 1 1 1	n: Action: EL RECEIVED ADD Date Informed:		DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Information Patient Informed Given:	PERSONNE Corrective A PERSONNE DI 1 1 1 1	n: Action: EL RECEIVED ADD Date Informed:		DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Number Patient Informed Given:	PERSONNE PERSONNE TI TI TI TI TI TI TI TI TI TI TI TI TI	n: Action: EL RECEIVED ADD Date Informed:		DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Informed Given: Diagnostic Study	S Information Corrective A PERSONNE DI: 1 : U /: LIVEF utical: NR	n: Action: EL RECEIVED ADD Date Informed:		DURE USED		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Informed Given: Diagnostic Study Radiopharmaceu	S Information Corrective A PERSONNE DI: 1 : U /: LIVEF utical: NR	n: Action: EL RECEIVED ADD Date Informed:	ITIONAL TRAINING			
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Informed Given: Diagnostic Study Radiopharmaceu	S Information Corrective A PERSONNE DI: 1 : U /: LIVEF utical: NR	n: Action: EL RECEIVED ADD Date Informed:	ITIONAL TRAINING			
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Informatic Patient Informed Given: Diagnostic Study Radiopharmaceu Radionuclide:	PERSONNE PERSONNE TI U U U U U U U U U U U U U U U U U U	n: Action: EL RECEIVED ADD Date Informed:	ITIONAL TRAINING			
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Informed Given: Diagnostic Study Radiopharmaceu Radiopharmaceu	PERSONNE PERSONNE TI U U U U U U U U U U U U U U U U U U	n: Action: EL RECEIVED ADD Date Informed: R Activity:	ITIONAL TRAINING			
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Informed Given: Diagnostic Study Radiopharmaceu Radionuclide:	Information Corrective A PERSONNE PERSONNE I I I I I I I I I I I I I I I I I I	n: Action: EL RECEIVED ADD Date Informed: R Activity:	ITIONAL TRAINING			
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Informed Given: Diagnostic Study Radiopharmaceu Radiopharmaceu	es Information Corrective A PERSONNE DERSONNE T I U UIVER UIVER UIVER UIVER UIVER UIVER	n: Action: EL RECEIVED ADD Date Informed: Activity: AL BLOOD FLOW	ITIONAL TRAINING			
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Information Patient Informed Given: Diagnostic Study Radiopharmaceu Radionuclide:	INFORMATION Corrective A PERSONNE PERSONNE IN IN IN IN IN IN IN IN IN IN IN IN IN	n: Naction: EL RECEIVED ADD Date Informed: Activity: AL BLOOD FLOW	ITIONAL TRAINING NR mCi	NR MBq		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Informatic Patient Informatic Patient Informed Given: Diagnostic Study Radiopharmaceu Radiopharmaceu Radiopharmaceu Radiopharmaceu Radiopharmaceu	es Information Corrective A PERSONNE DE	n: Action: EL RECEIVED ADD Date Informed: Activity: AL BLOOD FLOW TATIDE Activity: NA	ITIONAL TRAINING NR mCi	NR MBq		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Information Patient Information Patient Informed Given: Diagnostic Study Radiopharmaceu Radiopharmaceu Radiopharmaceu Radiopharmaceu	es Information Corrective A PERSONNE DE	n: Action: EL RECEIVED ADD Date Informed: Activity: AL BLOOD FLOW TATIDE Activity: NA	ITIONAL TRAINING NR mCi	NR MBq		
MD2 Cause: FAIL Corrective Action Action Number: MD2 1 Patient Informatic Patient Informatic Patient Informed Given: Diagnostic Study Radiopharmaceu Radiopharmaceu Radiopharmaceu Radiopharmaceu Radiopharmaceu	es Information Corrective A PERSONNE PERSONNE I I I I I I I I I I I I I I I I I I	n: Action: EL RECEIVED ADD Date Informed: Activity: AL BLOOD FLOW TATIDE Activity: NA	ITIONAL TRAINING NR mCi	NR MBq		

Source Number:	1					
Source/Radioactive Ma	aterial: UNSEA	ED SOURCE RADIO	PHARM Ra	dionuclide or Voltage (k'	Vp/MeV): TC-99M	
Manufacturer:	NR		Act	ivity:	NR Ci	NR GBq
Model Number:	NA					
Serial Number:	NA					
eferences:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
EN43731	10/25/2007		DCH	EVENT NOTIFICATI AGREEMENT STAT	ON REPORTED FRO	OM AN
LA070028	02/13/2008		DCH	AGREEMENT STAT	E EVENT REPORT	

Narrative:

Signet Diagnostic Imaging Services (dba South Florida Imaging Center) reported that a patient received 3.7 MBq (100 uCi) of I-123 instead of the prescribed thyroid scan using Tc-99m. An intern student from a local school was allowed to administer the diagnostic treatment, but didn't follow protocol. Corrective actions taken by the licensee included terminating the intern's position. Also, students are prohibited from administering any radioiodine to patients.

administering any radio				in s position. Also,	, students are prohibited from
Even	t Date: 08/09/2007	Discovery Date:	08/09/2007	Report Date:	08/10/2007
Licensee/Reporting Part	y Information:				
Agreement State Regula		Reciprocity:	NONE		
License Number:	FL-3439-3	Name:	SIGNET DIAGNO	STIC IMAGING SE	RVICES
NRC Docket Number:	NA	City:	PLANTATION		
NRC Program Code:	NA	State: FL	Zip Code: 33322		
Responsible NRC Regio	n: 1				
Site of Event:					
Site Name: PLANTATIC	N				
State: FL					
Additional Involved Part	y:				
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Regio	n: NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal C		N	
Agreement State Report		Investigation		Y	
Atomic Energy Act Mate			ord Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State:	Ŷ	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: FAILURE To	O FOLLOW PROCEDURE (OR WRONG PROCE	DURE USED		
Compositive Actions Inform					
Corrective Actions Inform Action Number: Corre					
MD2					
	SONNEL TERMINATED				
2 PROC	CEDURE MODIFIED				
Detient Information.					
Patient Information: Patient Number: 1					
Patient Informed: Y	Date Informed: 0	8/10/2007			
Given:					
Diagnostic Study:	NR				
Radiopharmaceutical:	NR				
Radionuclide: I-123	Activity:	0.1 mCi	3.7 MBq		
	, tourity.				
Intended:					
Diagnostic Study:	THYROID IMAGING				

MD2						
Source Number:	1					
Source/Radioactive Ma	terial: UNSEAL	ED SOURCE RADIO	PHARM Ra	dionuclide or Voltage (kVp/N	leV): I-123	
Manufacturer:	NR		Act	ivity:	0.0001 Ci	0.0037 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number: FL07-119	Entry Date: 10/23/2007	Retraction Date:	Coder Initials: DCH	Reference Type: AGREEMENT STATE E ^V	VENT REPORT	

Narrative:

The licensee reported that a nuclear medicine technologist performed a diagnostic cardiac imaging exam on himself. He administered himself with 1.46 GBq (39.4 mCi) of Tc-99m myoview for a stress test and followed it up with 0.43 GBq (11.6 mCi) of Tc-99m myoview for the rest test. Both administrations occurred on 8/6/2007 and were done without the licensee's or an authorized user's knowledge or consent. The technologist used a dose intended for a patient that did not show up for their scheduled exam. An authorized user was later notified of the incident by the technologist. The North Carolina Radioactive Materials Branch will inspect the licensee. The nuclear medicine technologist's employment was terminated.

Event Date	e: 0	8/06/2007	Discovery D	ate:	08/07/2007	Report Date:	08/08/2007
Licensee/Reporting Party Info	ormati	ion:					
Agreement State Regulated:	YS		Recipro	city:	NONE		
License Number:	NC-0	14-1144-2	Name:		PIEDMONT CARD	IOLOGY ASSOCIA	ATES
NRC Docket Number:	NA		City:		LENOIR		
NRC Program Code:	NA		State:	NC	Zip Code: NR		
Responsible NRC Region:	1						
ite of Event:							
Site Name: LENOIR							
State: NC							
dditional Involved Party:							
License Number:	NA		Name:		NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State:	NA	Zip Code: NA		
Responsible NRC Region:	NA						
ther Information:							
NRC Reportable Event:		Ν	Abnorm	nal O	ccurrence:	Ν	
Agreement State Reportable	Event	Y	Investig	atior	ו:	Y	
Atomic Energy Act Material:		Y	NMED	Reco	ord Complete:	Y	
Consultant Hired:		Ν	Event C	Close	d by Region/State:	Υ	

MD2 - MEDICAL EVENT

Event Cause:

MD2

Cause: INTENTIONAL VIOLATION

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 PERSONNEL TERMINATED

Patient Information:

Patient Number: 1

Patient Informed: Y Date Informed: 08/06/2007

Given:

Diagnostic Study: CARDIAC SCAN

Radiopharmaceutical: MYOVIEW

Radionuclide: TC-99M Activity: 51 mCi 1887 MBq

Intended:

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed:NA% Dose is Less Than Prescribed:NAEffect on Patient:

Source of Radiation:				
MD2				
Source Number:	1			
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Ra	adionuclide or Voltage (kVp/MeV): TC-99M
Manufacturer:	NR		Ad	ctivity: 0.0051 Ci 0.1887 GBq
Model Number:	NA			
Serial Number:	NA			
References:				
Reference Number:	Entry Date:	Retraction Date:	Coder Initials	: Reference Type:
EN43557	08/13/2007		DCH	EVENT NOTIFICATION REPORTED FROM AN AGREEMENT STATE
NC070041	09/12/2007		DCH	AGREEMENT STATE EVENT REPORT

Narrative:

During an NRC inspection it was determined that a technologist administered doses of Tc-99m that did not fall within the prescribed range and differed from the prescribed dosage by more than 20%. Myocardial imaging may involve a rest test and a stress test. Patients receiving the rest test are to receive 296 MBq (8 mCi) of Tc-99m, while patients receiving the stress test are to receive between 555 and 925 MBq (15 and 25 mCi) of Tc-99m. As of 6/5/2007, the technologist's practice was to administer the full dosage of about 1.11 GBq (30 mCi) when only the stress portion of the test was performed. When both portions of the test were performed, the technologist split a 1.11 GBq (30 mCi) dosage into two parts with the rest portion usually exceeding 444 MBq (12 mCi).

Event Da	ate: 06/05/2007	Discovery Date:	06/05/2007	Report Date:	06/05/2007
Licensee/Reporting Party In Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region: Site of Event: Site Name: CLOSTER State: NJ		Reciprocity: Name: City: State: NJ	REZZADEH, RUD CLOSTER	Y, M.D.	
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:				N Y Y N	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR Corrective Actions Informati Action Number: Corrective MD2 1 NOT REF	ion: e Action:				
Patient Information: Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: CAI	RDIOIMAGING				
Radiopharmaceutical: NR Radionuclide: TC-99M	Activity:	12 mCi	444 MBq		
Intended: Diagnostic Study: CAI Radiopharmaceutical: NR	RDIOIMAGING				
% Dose Exceeds Prescribed % Dose is Less Than Presc					

Source of Radiation:						
MD2						
Source Number:	1					
Source/Radioactive Mate	erial: UNSEAL	ED SOURCE RADIO	PHARM Ra	dionuclide or Voltage (kVp/N	MeV): TC-99M	
Manufacturer:	NR		Act	ivity:	0.008 Ci	0.296 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
ML071930453	07/19/2007		RLS	NOTICE OF VIOLATION	1	
ML071930453	07/19/2007		RLS	NRC LETTER		

Narrative:

The licensee reported that one of their customers stated that a patient prescribed to receive Tc-99m sestamibi for a heart scan showed no heart uptake. Instead, imaging revealed Tc-99m medronate (a bone imaging agent) had been injected. The customer had ordered a large dose of sestamibi and a biliary dose. Those were the only two doses drawn by the licensee at the time. No other clients that were dispensed doses from the same vial reported errors in imaging. Licensee investigation revealed no dispensing errors. The licensee has protocols in place to prevent dispensing errors. Since the error cannot be attr buted to the licensee, no corrective actions are necessary.

Event Da	te: 05/16	6/2007 Dis	covery Date	: 05/16/2007	Report Date:	06/05/2007
Licensee/Reporting Party Int	formation:					
Agreement State Regulated:	YS		Reciprocity	: NONE		
License Number:	LA-5119-l	L01	Name:	CARDINAL HEALT	н	
NRC Docket Number:	NA		City:	WEST MONROE		
NRC Program Code:	NA		State: LA	Zip Code: 71201		
Responsible NRC Region:	4					
Site of Event:						
Site Name: WEST MONRO	E					
State: LA						
Additional Involved Party:						
License Number:	NR		Name:	NR		
NRC Docket Number:	NR		City:	NR		
NRC Program Code:	NR		State: NR	Zip Code: NR		
Responsible NRC Region:	NR					
Other Information:						
NRC Reportable Event:	Ν		Abnormal (Occurrence:	Ν	
Agreement State Reportable	Event: Y		Investigatio	on:	Y	
Atomic Energy Act Material:	Y		NMED Red	cord Complete:	Y	
Consultant Hired:	Ν		Event Clos	ed by Region/State:	Y	

NR MBq

MD2

Cause: NOT REPORTED

Corrective Actions Information:

Action Number: Corrective Action:

MD2

1 NO CORRECTIVE ACTION TAKEN

Patient Information:

Patient Number: 1 Patient Informed: U	Date Informed:	
Given: Diagnostic Study:	BONE SCAN	
Radiopharmaceutical: Radionuclide: TC-99I		NR mCi
Intended: Diagnostic Study: Radiopharmaceutical:	CARDIAC SCAN SESTAMIBI/CARDIOLITE	

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation:

MD2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Ra	adionuclide or Voltage (kV	/p/MeV): TC-99M	
Manufacturer:	NR		Ac	ctivity:	NR Ci	NR GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
EN43432	06/25/2007		DCH	EVENT NOTIFICATIO		OM AN
LA070015	09/10/2007		DCH	AGREEMENT STATE	E EVENT REPORT	

Narrative:

The licensee reported that a patient was administered 1.18 GBq (32 mCi) of Tc-99m MAA instead of the prescribed 1.18 GBq (32 mCi) dose of Tc-99m myoview. The licensee ordered a myoview dose from the Gadsden Nuclear Pharmacy, but received MAA, which was mislabeled on the syringe. The dose was administered to the patient and the error was discovered when the patient was scanned. Dose estimate calculations determined that the patient received 7.04 cGy (rad) to the lungs. The root cause of the error was a failure by the pharmacist to select the correct drug. The pharmacist mistakenly placed a drug vial containing MAA into the myoview vial shield. Also, the technician performing the quality control test failed to properly interpret the results. Corrective actions taken by the pharmacy included modifying procedures to better identify the vials prior to use. In addition, a protocol has been implemented to validate the radiopharmaceutical quality control tests.

Event Dat	te: 10/31/	/2006 Discovery Date:	10/31/2006	Report Date:	12/22/2006
Licensee/Reporting Party Inf	ormation:				
Agreement State Regulated:	YS	Reciprocity:	NONE		
License Number:	AL-1357	Name:	APPLACHIAN CAF	RDIOVASCULAR A	ASSOCIATES
NRC Docket Number:	NA	City:	FORT PAYNE		
NRC Program Code:	NA	State: AL	Zip Code: NR		
Responsible NRC Region:	1				
Site of Event:					
Site Name: FORT PAYNE					
State: AL					
Additional Involved Party:					
License Number:	NR	Name:	GADSDEN NUCLE	AR PHARMACY	
NRC Docket Number:	NR	City:	NR		
NRC Program Code:	NR	State: NR	Zip Code: NR		
Responsible NRC Region:	NR				
Other Information:					
NRC Reportable Event:	Ν	Abnormal O	ccurrence:	Ν	
Agreement State Reportable	Event: Y	Investigation	1:	Ν	
Atomic Energy Act Material:	Y	NMED Reco	rd Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 PROCEDURE MODIFIED

Patient Number: 1 Patient Informed: Y	Data Inf	anna di 10/21/200					
Patient morned.	Date Init	ormed: 10/31/2006)				
Given:							
Diagnostic Study:	LUNG PERFUSIO	N					
Radiopharmaceutical:	MAA (MACROAG	GREGATED ALBU	MIN)				
Radionuclide: TC-99	M Ad	ctivity: 3	32 mCi	118	84 MBq		
Intended:							
Diagnostic Study:	CARDIAC						
Radiopharmaceutical:	MYOVIEW						
% Dose Exceeds Preso	cribed: NA						
% Dose is Less Than F	Prescribed: NA						
Effect on Patient:							
Source of Radiation:							
MD2							
Source Number:	1						
Source/Radioactive Ma	aterial: UNSEALED	SOURCE RADIO	PHARM	Radio	nuclide or Voltage (kVp/MeV): TC-99M	
Manufacturer:	NR			Activit	y:	0.032 Ci	1.184 GBq
Model Number:	NA						
Serial Number:	NA						
Device/Associated Equi	ipment:						
MD2							
Device Number: 1							
	RINGE				Number:	NA	
Manufacturer: NF	R			Serial	Number:	NA	
References:							
Reference Number:	Entry Date: F	Retraction Date:	Coder Initia	als:	Reference Type:		
AL070019	05/07/2007		DCH		AGREEMENT STA	TE EVENT REPORT	

Last Updated: 01/07/2008

Narrative:

Sibley Memorial Hospital reported that a patient receiving a gall bladder study was administered Ga-67 instead of the prescribed 185 MBq (5 mCi) dose of Tc-99m. Both syringes containing the doses were located in the same case, which was delivered to Sibley Memorial Hospital by Mallinckrodt. The patient was informed of the error. This event was retracted on 3/13/2007 after Sibley Memorial Hospital concluded that no reporting criteria were met.

no reporting criteria were me	et.		·	·
Event Dat	te: 03/12/2007	Discovery Date: 03/12/2007	Report Date:	03/12/2007
Licensee/Reporting Party Inf	formation:			
Agreement State Regulated:	NO	Reciprocity: NONE		
License Number:	08-07398-03	Name: SIBLEY MEM	IORIAL HOSPITAL	
NRC Docket Number:	03014754	City: WASHINGTO	ON	
NRC Program Code:	02120	State: DC Zip Code: 20	0016	
Responsible NRC Region:	1			
Site of Event:				
Site Name: WASHINGTON				
State: DC				
Additional Involved Party:				
License Number:	NA	Name: NA		
NRC Docket Number:	NA	City: NA		
NRC Program Code:	NA	State: NA Zip Code: N/	Α	
Responsible NRC Region:	NA			
Other Information:				
NRC Reportable Event:	Ν	Abnormal Occurrence:	Ν	
Agreement State Reportable	Event: N	Investigation:	Ν	
Atomic Energy Act Material:	Y	NMED Record Complete:	Y	
Consultant Hired:	Ν	Event Closed by Region/S	State: N	
Event Cause: MD2 Cause: HUMAN ERROF Corrective Actions Information Action Number: Corrective MD2 1 NOT REP	on: Action:			
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed: 03/	12/2007		
Given:				
Diagnostic Study: NR				
Radiopharmaceutical: NR Radionuclide: GA-67	Activity:	NR mCi NR M	Ba	
	···j·			
Intended: Diagnostic Study: GAL	LBLADDER			
Radiopharmaceutical: NR				
% Dose Exceeds Prescribed % Dose is Less Than Prescr Effect on Patient: Source of Radiation: MD2				
1911 17				

Source Number:	1								
	-	UNSEAL	ED SOURCE RADIO	PHARM	Radio	onuclide or Volta	ge (kVp/M	eV): TC-99M	
Manufacturer:		NR			Activ	ity:		0.005 Ci	0.185 GBq
Model Number:		NA							
Serial Number:		NA							
Device/Associated MD2 Device Number: Device Name: Manufacturer:	1 SYRING NR					el Number: I Number:	NA NA		
References:									
Reference Numbe	er: Ent	ry Date:	Retraction Date:	Coder Initia	als:	Reference Typ	e:		
EN43229	04/1	9/2007	03/13/2007	DCH		EVENT NOTIFI	CATION		
ML070820340	01/0	07/2008		RLS		LICENSEE REP	PORT		

Last Updated: 03/29/2007

Narrative:

The licensee reported that a patient received I-125 seed implants for treatment of prostate cancer and the resulting dose that was 6.9% greater than intended. The prescribed dose for the treatment was 14,500 cGy (rad) and the given dose was 15,500 cGy (rad). It was determined that the wrong units were entered into the dose planning computer. The incident was retracted on 3/28/2007, based on the fact that the given dose was below the reporting criteria.

that the given dose was being	· -				
Event Da	ate: 03/23/2007	Discovery Date:	03/23/2007	Report Date:	03/23/2007
Licensee/Reporting Party Inf	formation:				
Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	I: NO 37-11866-01 03003151 02230 1	Reciprocity: Name: City: State: PA	NONE LANCASTER GEN LANCASTER Zip Code: 17603	IERAL HOSPITAL	
Site of Event: Site Name: LANCASTER State: PA					
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	Name: City: State: NA	NA NA Zip Code: NA		
Other Information:					
NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:				N N Y N	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROF Corrective Actions Informati Action Number: Corrective MD2 1 NOT REP	t ion: re Action:				
Patient Information:					
Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Therapeutic Procedure: BR/ Organ: PRO Radiopharmaceutical: NA Radionuclide: I-125	OSTATE	NR mCi	NR MBq	Dose: 15500	rad 155 Gy
Intended: Therapeutic Procedure: BR/	ACHY, MANUAL IMPLANT		NR MBq	Dose: 14500	
% Dose Exceeds Prescribed % Dose is Less Than Prescr Effect on Patient: Source of Radiation: MD2					

Source Number: 1						
Source/Radioactive Mater	rial: SEALED	SOURCE BRACHYT	HERAPY Radi	onuclide or Voltage (kVp/Me	eV): I-125	
Manufacturer:	NR		Activ	vity:	NR Ci	NR GBq
Model Number:	NR					
Serial Number:	AGGREG	BATE				
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
EN43256	03/29/2007	03/28/2007	DCH	EVENT NOTIFICATION		

Narrative:

Emanuel Hospital (EH) reported that a patient received 24% less dose than prescr bed during treatment. A review of the event by EH and the State determined that the material involved (Pd-103) was accelerator produced and is not regulated by the NRC. Therefore, the incident is not reportable and was retracted on 3/14/2007.

is not reportable and was retrac	ted on 3/14/2007.					
Event Date:	11/01/2006	Discovery Date:	03/05/2007	Report Date:	03/05/2007	
Licensee/Reporting Party Inform	nation:					
Agreement State Regulated: YS	6	Reciprocity:	NONE			
License Number: OF	R-90014	Name:	EMANUEL HOSPI	TAL		
NRC Docket Number: NA	N .	City:	PORTLAND			
NRC Program Code: NA	N	State: OR	Zip Code: NR			
Responsible NRC Region: 4						
Site of Event:						
Site Name: PORTLAND						
State: OR						
Additional Involved Party:						
License Number: NA	A Contraction of the second seco	Name:	NA			
NRC Docket Number: NA	A Contraction of the second seco	City:	NA			
NRC Program Code: NA	A Contraction of the second seco	State: NA	Zip Code: NA			
Responsible NRC Region: NA	N .					
Other Information:						
NRC Reportable Event:	Ν	Abnormal O	ccurrence:	Ν		
Agreement State Reportable Eve	ent: Y	Investigation	ו:	Y		
Atomic Energy Act Material:	Ν	NMED Reco	ord Complete:	Y		
Consultant Hired:	Ν	Event Close	d by Region/State:	Y		
Event Cause: MD2 Cause: NOT REPORTED Corrective Actions Information: Action Number: Corrective Ac MD2 1 NOT REPOR Patient Information: Patient Number: 1						
Patient Informed: U	Date Informed:					
Given:						
Therapeutic Procedure: BRACH	IY, TYPE NOT REPOF	RTED				
Organ: NR						
Radiopharmaceutical: NA Radionuclide: PD-103	A otivity (NR MBg		D rod	NR Gy
Radionucide. PD-103	Activity:	NR mCi		Dose: N	R rad	NR Gy
Intended:						
Therapeutic Procedure: BRACH	IY, TYPE NOT REPOP	RTED				
Organ: NR						
Radiopharmaceutical: NA						
Radionuclide: PD-103	Activity:	NR mCi	NR MBq	Dose: N	R rad	NR Gy
% Dose Exceeds Prescribed:	NA					
% Dose is Less Than Prescribed						
Effect on Patient:						
Source of Radiation:						
MBA						

Source Number:	1						
Source/Radioactive Ma	aterial: SEALED	SOURCE BRACHYT	HERAPY	Radio	onuclide or Voltage (kVp/Me	V): PD-103	
Manufacturer:	NR			Activi	ty:	NR Ci	NR GBq
Model Number:	NR						
Serial Number:	NR						
References:							
Reference Number:	Entry Date:	Retraction Date:	Coder Initi	ials:	Reference Type:		
EN43214	03/12/2007	03/14/2007	DCH		EVENT NOTIFICATION REAGREEMENT STATE	EPORTED FROM	AN
LTR100908	09/14/2010		DCH		AGREEMENT STATE LET	TER	

Last Updated: 03/09/2007

Narrative:

The licensee reported that the wrong patient was administered 555 MBq (15 mCi) of Tc-99m Cardiolite. The patient was scheduled for a nonnuclear stress treatment. Another patient was scheduled to receive the Cardiolite administration, but failed to show up for the administration. The technologist failed to follow procedures for patient identification and mistakenly administered the dose to the wrong patient. The physician notified the patient of the error and deemed that no correction action to the patient was necessary. The technologist received additional instruction on the procedures. This event was retracted on 3/5/2007 because the patient's dose did not reach the threshold for reportability.

threshold for reportability.				
Event Date	: 02/27/2007	Discovery Date: 02/27/20	07 Report Date:	02/27/2007
NRC Docket Number: 0 NRC Program Code: 0		Reciprocity: NONE Name: HANNIBAI City: HANNIBAI State: MO Zip Code:		LLC
Site of Event: Site Name: HANNIBAL State: MO				
NRC Docket Number: I NRC Program Code: I	NA NA NA	Name: NA City: NA State: NA Zip Code:	NA	
Other Information: NRC Reportable Event: Agreement State Reportable E Atomic Energy Act Material: Consultant Hired:	N Event: N Y N	Abnormal Occurrence: Investigation: NMED Record Complet Event Closed by Region		
Old Cause: PROCEDURE NO Corrective Actions Information Action Number: Corrective A MD2	DT FOLLOWED n:	WRONG PROCEDURE USE IAL TRAINING	D	
Patient Information: Patient Number: 1 Patient Informed: Y Given: Diagnostic Study: CARI Radiopharmaceutical: SEST	Date Informed: 02/2 DIAC SCAN FAMIBI/CARDIOLITE	7/2007		
Radionuclide: TC-99M	Activity:	15 mCi 555	MBq	

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient:

Source of Radiation:				
MD2				
Source Number: 1				
Source/Radioactive Material:	UNSEALED SOURCE RADIOP	HARM Radionud	clide or Voltage (kVp/Me	eV): TC-99M
Manufacturer:	NR	Activity:	(0.015 Ci 0.555 GBq
Model Number:	NR			
Serial Number:	NR			
Device/Associated Equipment	t:			
Device Number: 1				
Device Name: SYRINGE	E	Model Nu	umber: NA	
Manufacturer: NR		Serial Nu	umber: NA	
References:				
Reference Number: Entr	ry Date: Retraction Date:	Coder Initials: Re	eference Type:	
EN43193 03/0	05/2007 03/05/2007	RLS EV	ENT NOTIFICATION	
LTR070228 03/0	05/2007	RLS NF	RC LETTER	
LTR070309 03/0	9/2007	RLS NF	RC LETTER	

Source of Radiation:

MD2

Narrative:

The licensee reported that a patient was administered a diagnostic dose of 1.11 MBq (30 uCi) of I-123 instead of the prescribed I-131 scan. The patient had no thyroid. The licensee counseled and disciplined the involved technologist. The licensee will review their medical directive for verification.

for verification.					
Event Date: 1	10/06/2006 D i	scovery Date:	10/06/2006	Report Date:	10/20/2006
Licensee/Reporting Party Informat Agreement State Regulated: YS License Number: FL-31 NRC Docket Number: NA NRC Program Code: NA Responsible NRC Region: 1 Site of Event: Site Name: JACKSONVILLE State: FL		City:	NONE SHANDS JACKSO JACKSONVILLE Zip Code: 33209	NVILLE MEDICAL	CENTER, INC.
Additional Involved Party:License Number:NANRC Docket Number:NANRC Program Code:NAResponsible NRC Region:NAOther Information:NA		City:	NA NA Zip Code: NA		
NRC Reportable Event: Agreement State Reportable Event Atomic Energy Act Material: Consultant Hired:	N : Y Y N			N Y Y Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR Old Cause: WRONG SYRINGE SE Corrective Actions Information: Action Number: Corrective Action MD2 1 PERSONNEL R	n:	AGE CART			
Patient Information: Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: NR					
Radiopharmaceutical: NR Radionuclide: I-123	Activity:	0.03 mCi	1.11 MBq		
Intended: Diagnostic Study: THYROID UPTAKE MEASUREMENT					
Radiopharmaceutical: SODIUM IODIDE					
% Dose Exceeds Prescribed: % Dose is Less Than Prescribed: Effect on Patient:	NA NA				

Source Number:	I					
Source/Radioactive Mate	rial: UNSEAL	ED SOURCE RADIO	PHARM R	adionuclide or Voltage	e (kVp/MeV): I-123	
Manufacturer:	NR		A	ctivity:	0.00003 Ci	0.00111 GBq
Model Number:	NA					
Serial Number:	NA					
Source Number:	2					
Source/Radioactive Mate	rial: UNSEAL	ED SOURCE RADIO	PHARM R	adionuclide or Voltage	e (kVp/MeV): I-131	
Manufacturer:	NR		A	ctivity:	NR Ci	NR GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials	: Reference Type:	:	
FL06-130	02/26/2007		DCH	AGREEMENT ST	TATE EVENT REPORT	

Narrative:

The licensee reported that a 59-year-old female patient being treated for cervical cancer received 844.5 cGy (rad) to the intended area instead of the prescribed dose of 2046.5 cGy (rad). The planned dose was to be administered over a 39-hour time period using a low dose rate (LDR) after the first 16.09 hours, but on 2/6/2007 between 0630 and 0717 EST, the patient pulled the applicator out approximately 4 cm. The licensee calculated the dose to the incorrect vaginal sites due to the displacement of the sources. If the full dose had been delivered as prescribed, the upper vagina would have received 2926.56 cGy (rad). The patient and the patient's doctor were notified of the event and the patient refused further treatment. This event was determined to not be a reportable medical event due to patient intervention.

Event Da	ate: ()2/06/2007	Discovery Dat	e: 02/06/2007	Report Date:	02/06/2007
Licensee/Reporting Party Ir	nformat	ion:				
Agreement State Regulated	I: NO		Reciproci	ty: NONE		
License Number:	06-00	854-03	Name:	SAINT FRANCIS	HOSPITAL & MED	ICAL CENTER
NRC Docket Number:	0300	1246	City:	HARTFORD		
NRC Program Code:	02230	D	State: C	T Zip Code: 06105		
Responsible NRC Region:	1					
Site of Event:						
Site Name: HARTFORD						
State: CT						
Additional Involved Party:						
License Number:	NA		Name:	NA		
NRC Docket Number:	NA		City:	NA		
NRC Program Code:	NA		State: N	A Zip Code: NA		
Responsible NRC Region:	NA					
Other Information:						
NRC Reportable Event:		Ν	Abnormal	Occurrence:	Ν	
Agreement State Reportabl	e Event	: N	Investigat	ion:	Ν	
Atomic Energy Act Material	:	Y	NMED Re	ecord Complete:	Y	
Consultant Hired:		N	Event Clo	sed by Region/State:	N	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: PATIENT INTERVENTION Old Cause: PATIENT REMOVED SOURCE Corrective Actions Information: Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Number: 1 Patient Informed: Y	Date Informed:					
Given:						
Therapeutic Procedure: BRACHY	, REMOTE AFTER	LOADER, LDR				
Organ: CERVIX						
Radiopharmaceutical: NA	A otivith (150.2 mCi	5561 1 MPa	Decei	944 5 rod	9 4 4 5 CV
adionuclide: CS-137	Activity:	150.3 mCi	5561.1 MBq	Dose:	844.5 rad	8.445 Gy
ntended:						
Therapeutic Procedure: BRACHY	, REMOTE AFTER	LOADER, LDR				
Organ: CERVIX						
Radiopharmaceutical: NA				_		
adionuclide: CS-137	Activity:	150.3 mCi	5561.1 MBq	Dose:	2046.5 rad	20.465 Gy
Dose Exceeds Prescribed:	NA					
Dose is Less Than Prescribed:	58.7					
ffect on Patient:						
atient Number: 1A						
atient Informed: Y	Date Informed:					
iven:						
herapeutic Procedure: BRACHY	, REMOTE AFTER	LOADER, LDR				
Organ: VAGINA						
adiopharmaceutical: NA						
adionuclide: CS-137	Activity:	150.3 mCi	5561.1 MBq	Dose:	1225 rad	12.25 Gy
ntended:						
Therapeutic Procedure: BRACHY	, REMOTE AFTER	LOADER, LDR				
Drgan: VAGINA						
Radiopharmaceutical: NA						
adionuclide: CS-137	Activity:	150.3 mCi	5561.1 MBq	Dose:	2926.6 rad	29.266 Gy
Dose Exceeds Prescribed:	NA					
Dose is Less Than Prescribed:	58.1					
ffect on Patient:						
atient Number: 1B						
atient Informed: Y	Date Informed:					
iven:						
herapeutic Procedure: BRACHY	, REMOTE AFTER	LOADER, LDR				
Organ: VAGINA						
Radiopharmaceutical: NA				_		
Radionuclide: CS-137	Activity:	150.3 mCi	5561.1 MBq	Dose:	267 rad	2.67 Gy
ntended:						
Therapeutic Procedure: BRACHY	, REMOTE AFTER	LOADER, LDR				
Organ: VAGINA						
Radiopharmaceutical: NA						
Radionuclide: CS-137	Activity:	150.3 mCi	5561.1 MBq	Dose:	465 rad	4.65 Gy
Dose Exceeds Prescribed:	NA					
6 Dose is Less Than Prescribed:	42.6					
ffect on Patient:						
urce of Radiation:						
02						

Source Number:	1									
Source/Radioactive	Material:	SEALED S	SOURCE BR	ACHYT	HERAPY	Radio	nuclide or Voltage (I	kVp/MeV)	: CS-137	
Manufacturer:		NR				Activit	ty:	150).3 Ci	5561.1 GBq
Model Number:		NR								
Serial Number:		AGGREG	ATE							
Device/Associated E	quipmen	t:								
MD2										
Device Number:	1									
Device Name:	REMOTE	E AFTERLO	ADER LDR			Mode	I Number:			
Manufacturer:						Serial	Number:	NR		
References:										
Reference Number	: Enti	ry Date:	Retraction	Date:	Coder Initia	als:	Reference Type:			
EN43147	02/1	2/2007	03/07/2007		DCH		EVENT NOTIFICAT	ΓΙΟΝ		
LTR070305	03/0	5/2007			RLS		NRC LETTER			
ML071010378	04/3	80/2007			RLS		LICENSEE REPOR	RT		

RLS

REGION REPORT

ML071010378

04/30/2007

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Narrative:

The licensee reported that a patient receiving treatment for liver cancer using Y-90 microspheres was administered 0.24 GBq (6.5 mCi) instead of the prescribed 0.36 GBq (9.8 mCi). This resulted in the patient receiving 5,900 cGy (rad) to the left lobe of the liver rather than 10,000 cGy (rad). The licensee was using Y-90 SirTex Sirspheres and an intrahepatic catheter. Approximately half-way through the administration, the physician temporarily halted the procedure in order to flush the catheter and to verify positioning of the administered microspheres using angiography. As the physician attempted to inject the contrast media for the angiography, he noted resistance and slow flow, indicating that the patient's vasculature within the tumor could not accommodate additional microspheres. The physician elected to terminate the procedure and revised the written directive. As the physician halted treatment, the remaining microspheres in the delivery device and the catheter appeared to be clumped together. The licensee was unable to determine if the clumping of the microspheres contributed to this event. The licensee sent the delivery device to the manufacturer for examination. This event was retracted on 1/11/2007 after discussions with NRC Region III determined that this event did not meet the criteria for a reportable event because the physician terminated the procedure due to the medical condition of the patient.

Event Da	te: 11	1/07/2006	Discovery Dat	e: 11/07/20	06 Report Date	e: 11/08/2006
Licensee/Reporting Party In	formatio	on:				
Agreement State Regulated:	NO		Reciproci	y: NONE		
License Number:	21-013	33-01	Name:	WILLIAM E	BEAUMONT HOSPITAI	L
NRC Docket Number:	03002	006	City:	ROYAL OA	АК	
NRC Program Code:	02110		State: M	Zip Code:	48073	
Responsible NRC Region:	3					
Site of Event:						
Site Name: ROYAL OAK						
State: MI						
Additional Involved Party:						
License Number:	NA		Name:	NA		
NRC Docket Number:	NA		City:	NA		
NRC Program Code:	NA		State: N	A Zip Code:	NA	
Responsible NRC Region:	NA					
Other Information:						
NRC Reportable Event:		Ν	Abnormal	Occurrence:	Ν	
Agreement State Reportable	Event:	Ν	Investigat	ion:	Y	
Atomic Energy Act Material:		Υ	NMED Re	cord Complet	e: Y	
Consultant Hired:		Ν	Event Clo	sed by Regior	n/State: Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: PATIENT OTHER Old Cause: NOT REPORTED

Corrective Actions Information:

Action Number: Corrective Action:

MD2

EQUIPMENT RETURNED TO MANUFACTURER FOR REPAIR OR DISPOSAL

Patient Number:		-	- to before a de 11/0	0/0000					
Patient Informed:	Y	L	ate Informed: 11/0	9/2006					
Given:									
Therapeutic Proce	edure	BRACHY, N	/IANUAL IMPLANT						
Organ:		LIVER							
Radiopharmaceut	tical:	NA							
Radionuclide: Y	′-90		Activity:	6.5 mCi	24	40.5 MBq	Dose:	59 rad	0.59 Gy
Intended:									
Therapeutic Proc	edure	BRACHY, N	ANUAL IMPLANT						
Organ:		LIVER							
Radiopharmaceut	tical:	NA							
Radionuclide: Y	′-90		Activity:	9.8 mCi	36	62.6 MBq	Dose:	100 rad	1 Gy
% Dose Exceeds	Presc	cribed:	NA						
% Dose is Less T	han P	rescribed:	41						
Effect on Patient:									
Source of Radiatio	on:								
MD2									
Source Number:		1							
Source/Radioacti	ve Ma	terial: MICF	ROSPHERES		Rad	ionuclide or	Voltage (k	Vp/MeV): Y-90	
Manufacturer:		SIRT	EX MEDICAL		Activ	/ity:		0.098 Ci	3.626 GBq
Model Number:		SIR-S	SPHERES						
Serial Number:		AGG	REGATE						
Device/Associated	l Equi	pment:							
MD2									
Device Number:	1				Mad	al Nicurala a ur			
Device Name:		PLICATOR				el Number:		SIR-SPHERES	
Manufacturer:	SI	RTEX MEDIC	AL		Seria	al Number:		NR	
References:									
Reference Numb	ber:	Entry Date			Initials:	Referenc			
EN42975		11/13/2006		DCH			OTIFICAT		
ML063250105		12/05/2006		RLS			E REPOR	T	
LTR070116		01/18/2007		DCH		NRC LET			
ML070160142		01/26/2007		RLS		NRC LET			
ML070160316		01/26/2007	(RLS		INSPECT	ION REPC	NK I	

Narrative:

The licensee (dba Cardiology Associates) reported that a patient was administered 1.11 GBq (30 mCi) of Tc-99m myoview. However, imaging of the patient revealed the lungs and liver. The licensee believes that the dose contained Tc-99m MAA instead of the prescribed Tc-99m myoview. Cox Nuclear Pharmacy was contacted, but they do not believe the bottle was mislabeled. They stated that the bottle was filled strictly within their procedures. They also stated that the company that provides myoview says that under certain circumstances it can show up in the lungs and liver.

show up in the lungs and live	1.				
Event Date	: 07/03/2006	Discovery Date:	07/03/2006	Report Date:	07/24/2006
Licensee/Reporting Party Info	rmation:				
NRC Docket Number: I NRC Program Code: I	YS FL-1815-1 NA NA 1	City:		DIOLOGY ASSOCI	ATES
Site of Event: Site Name: PANAMA CITY State: FL					
NRC Docket Number: I NRC Program Code: I	NR NR 1	City:	COX NUCLEAR F PANAMA CITY Zip Code: 32401	PHARMACY	
Other Information:					
NRC Reportable Event: Agreement State Reportable E Atomic Energy Act Material: Consultant Hired:	N Event: Y Y N	Abnormal Oc Investigation NMED Reco Event Closed		N Y Y : Y	
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: NOT REPORTED Old Cause: NOT REPORTED Old Cause: NOT REPORTED Corrective Actions Information Action Number: Corrective A MD2 1 NOT REPORTED) n: Action:				
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed: 07/	03/2006			
Given: Diagnostic Study: LUNC	3				
Radiopharmaceutical: MAA/ Radionuclide: TC-99M	PULMOLITE (MACROA)	GGREGATED 30 mCi	1110 MBq		
Intended: Diagnostic Study: CARI	DIAC				
Radiopharmaceutical: MYO' Radionuclide: TC-99M	VIEW Activity:	30 mCi	1110 MBq		
% Dose Exceeds Prescribed: % Dose is Less Than Prescrib Effect on Patient:					

Source of Radiation:

MD2						
Source Number:	1					
Source/Radioactive Ma	terial: UNSEAL	ED SOURCE RADIO	PHARM Rad	lionuclide or Voltage (kVp/	(MeV): TC-99M	
Manufacturer:	NR		Acti	vity:	0.03 Ci	1.11 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
FL06-094	08/30/2006		DCH	AGREEMENT STATE E	EVENT REPORT	

Narrative:

The licensee reported administering a gamma knife treatment to the incorrect area of the patient. The physician treated the wrong Trigeminal nerve. Follow up inspection determined that the licensee treated the area prescribed by the physician and followed the written directive. The incident occurred due to an error in the physician's notes that lead to the incorrect site being treated. Partially into the treatment, the possibility of the site being incorrect was addressed by a member of the treatment team. The treatment was immediately terminated. Investigation determined that the patient received 3,200 cGy (rad) to the wrong site. The physician and patient were informed. The physician and patient made the decision to treat the correct site. The patient then received the treatment to the correct site per a new prescription and written directive. Corrective actions taken by the licensee included requiring three separate double checks of their procedure on the day of treatment. Prior to being sedated, the patient will be asked which side the pain is on. When the patient is framed, the nurse shall ask the neurosurgeon which side is to be treated. That will be verified with the patient. Lastly, just prior to treatment, both the neurosurgeon and the radiation oncologist will be once again asked which side is to be treated.

Event Dat	e: 1	0/03/2005	Dis	covery Date:	10/03/2005	Report Date:	08/23/2006
Licensee/Reporting Party Inf	ormati	on:					
Agreement State Regulated:	YS			Reciprocity:	NONE		
License Number:	OR-90)946		Name:	PROVIDENCE PC	RTLAND MEDICAL	CENTER
NRC Docket Number:	NA			City:	PORTLAND		
NRC Program Code:	NA			State: OR	Zip Code: NR		
Responsible NRC Region:	4						
Site of Event:							
Site Name: PORTLAND							
State: OR							
Additional Involved Party:							
License Number:	NA			Name:	NA		
NRC Docket Number:	NA			City:	NA		
NRC Program Code:	NA			State: NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν		Abnormal O	ccurrence:	Ν	
Agreement State Reportable	Event:	Y		Investigation	n:	Y	
Atomic Energy Act Material:		Y		NMED Reco	ord Complete:	Y	
Consultant Hired:		Ν		Event Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR Old Cause: FAILURE TO VERIFY TREATMENT SITE Corrective Actions Information: Action Number: Corrective Action: MD2

1 PROCEDURE MODIFIED

Patient Number:	1						
Patient Informed: \	Y	Date Informed: 10	/03/2005				
Given:							
Therapeutic Procee	dure: GAMMA	A KNIFE					
Organ:	HEAD						
Radiopharmaceutio	cal: NA						
Radionuclide: CC	0-60	Activity:	NR mCi	NR MBq	Dose:	3200 rad	32 Gy
Intended:							
Therapeutic Procee	dure: GAMMA	A KNIFE					
Organ:	HEAD						
Radiopharmaceutic	cal: NA						
Radionuclide: CC	D-60	Activity:	NR mCi	NR MBq	Dose:	0 rad	0 Gy
% Dose is Less That Effect on Patient: Source of Radiation MD2 Source Number:		d: NA					
Source/Radioactive Manufacturer: Model Number: Serial Number:	N N N	EALED SOURCE GA R R R	MMA KNIFE	Radionuclide or Activity:	Voltage (k	Vp/MeV): CO-6(NR Ci) NR GBq
Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated E	N N N	R R	MMA KNIFE		Voltage (k		
Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated R MD2	N N R Equipment:	R R	MMA KNIFE		Voltage (k		
Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated B MD2 Device Number:	N N Equipment: 1	R R R	MMA KNIFE	Activity:		NR Ci	
Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated B MD2 Device Number: Device Name:	N N Equipment: 1 GAMMA KN	R R R	MMA KNIFE	Activity: Model Number:		NR Ci	
Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated B MD2 Device Number:	N N Equipment: 1	R R R	MMA KNIFE	Activity:		NR Ci	
Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated B MD2 Device Number: Device Name:	N N Equipment: 1 GAMMA KN	R R R	MMA KNIFE	Activity: Model Number:		NR Ci	
Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated R MD2 Device Number: Device Name: Manufacturer:	N N Equipment: 1 GAMMA KN NR	R R IIFE UNIT		Activity: Model Number: Serial Number:		NR Ci	
Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated B /ID2 Device Number: Device Name: Manufacturer: References:	N N Equipment: 1 GAMMA KN NR	R R IIFE UNIT Date: Retraction		Activity: Model Number: Serial Number: ials: Reference	• Type: OTIFICAT	NR Ci NR NR	NR GBq
Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated B MD2 Device Number: Device Name: Manufacturer: References: Reference Number	N Equipment: 1 GAMMA KN NR er: Entry I	R R IIFE UNIT Date: Retraction 2006	Date: Coder Init	Activity: Model Number: Serial Number: ials: Reference EVENT No AGREEMI	• Type: OTIFICAT ENT STAT	NR Ci NR NR	NR GBq

Narrative:

Fort Sanders Parkwest Hospital reported that a patient was injected with Tc-99m sestamibi for myocardial uptake instead of the intended Tc-99m medronate for bone imaging. The Cardinal Health pharmacist failed to select the correct drug for the prescription. Additionally, both the pharmacist and the dispensing technician failed to verify that the drug vial matched the prescription label prior to dispensing the dose. An inservice training session was held for all pharmacists and technicians at Cardinal Health to remind them of the proper procedures for sorting prescriptions and drawing doses.

prescriptions and drawing d	10565.				
Event Da	te: 05/09/2006	Discovery Date:	05/09/2006	Report Date:	06/02/2006
Licensee/Reporting Party Int Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:		City:	NONE CARDINAL HEAL [*] KNOXVILLE Zip Code: 37921	ГН	
Site of Event: Site Name: KNOXVILLE State: TN					
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NR NR 1	City:	FORT SANDERS KNOXVILLE Zip Code: 37916	PARKWEST HOSF	PITAL
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:		Abnormal Oc Investigation NMED Reco Event Closed		N N Y Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROF Old Cause: RADIOPHARM/ Corrective Actions Informati Action Number: Corrective MD2 1 PERSON	ACEUTICAL IMPROPERL'				
Patient Information: Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: MY	OCARDIAL PERFUSION				
Radiopharmaceutical: SES Radionuclide: TC-99M	STAMIBI/CARDIOLITE Activity:	NR mCi	NR MBq		
Intended: Diagnostic Study: BOI	NE SCAN				
Radiopharmaceutical: MEI Radionuclide: TC-99M	DRONATE Activity:	NR mCi	NR MBq		
% Dose Exceeds Prescribed % Dose is Less Than Presc Effect on Patient:					

Source of Radiation:

MD2					
Source Number:	1				
Source/Radioactive Ma	aterial: UNSEA	ED SOURCE RADIO	PHARM Rad	dionuclide or Voltage (kVp/MeV): TC-99	M
Manufacturer:	NR		Act	ivity: NR Ci	NR GBq
Model Number:	NA				
Serial Number:	NA				
References:					
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:	
TN06069	07/19/2006		DCH	AGREEMENT STATE EVENT REPOR	Т
TN06069A	02/21/2008		DCH	AGREEMENT STATE EVENT REPOR	Т

Narrative:

The licensee reported that a patient was injected with 0.37 GBq (10 mCi) of Tc-99m sestamibi instead of the intended TI-201 for a stress study. The order was sent for the wrong patient. The patient and the patient's physician were notified of the incident. The licensee implemented a procedure for all radionuclide injections to require two individuals (the nuclear cardiology technician and either a nuclear cardiology nurse or the manager) to verify the correct patient and dosage.

cardiology nurse or the man	• •				
Event Dat	te: 04/04/2006	Discovery Date:	04/04/2006	Report Date:	04/13/2006
Licensee/Reporting Party Inf Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:		City:	NONE CENTENNIAL ME NASHVILLE Zip Code: 37203	DICAL CENTER	
Site of Event: Site Name: NASHVILLE State: TN					
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	City:	NA NA Zip Code: NA		
Other Information:					
NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:				N N Y Y	
Event Cause: MD2 Cause: HUMAN ERROF Old Cause: WRONG PATIE Corrective Actions Informati Action Number: Corrective MD2 1 NEW PRO	ENT SELECTED				
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed: (04/04/2006			
Given: Diagnostic Study: CAF	RDIAC SCAN				
Radiopharmaceutical: SES Radionuclide: TC-99M	STAMIBI/CARDIOLITE Activity:	10 mCi	370 MBq		
Intended: Diagnostic Study: CAF	RDIAC SCAN				
Radiopharmaceutical: THA Radionuclide: TL-201	ALLOUS CHLORIDE Activity:	NR mCi	NR MBq		
% Dose Exceeds Prescribed % Dose is Less Than Prescr Effect on Patient: Source of Radiation: MD2					

Source Number:	1				
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rac	ionuclide or Voltage (kVp/MeV): TC	-99M
Manufacturer:	NR		Acti	vity: 0.01 Ci	0.37 GBq
Model Number:	NA				
Serial Number:	NA				
References:					
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:	
TN06052	07/18/2006		DCH	AGREEMENT STATE EVENT REF	PORT

Narrative:

The licensee reported that a patient was injected with Tc-99m choletec for a hepatobiliary study instead of the intended Tc-99m MAG-3 for a renal study. The licensee ordered the MAG-3 dose, but the scan revealed a hepatobiliary uptake. An investigation revealed that the dose was mistakenly dispensed as choletec. The prescription label for the MAG-3 dose was printed out and placed on a counter. A vial of choletec was mistakenly placed on the label, which a pharmacist signed, indicating his verification of proper drug selection. The dispensing technician then used this vial to fill the dose which was sent to the customer. The root cause of the event was the drug selection error. Both the pharmacist and the technician failed in their duty to verify that the drug vial matched the prescription label prior to dispensing the dose. Three changes were made in the licensee's dispensing procedure to prevent recurrence. All technicians will now perform a second verification step for the prescriptions they will be filling; only pharmacists will be allowed to remove kits from the kit storage area; and only pharmacists will be placing kits on the prescription labels. The licensee converted to a new numbering system for drug kits to further help avoid drug selection errors. The pharmacist and dispensing technician were given written warnings.

Event Dat	t e: 0	1/16/2006	Disc	overy Date:	02/06/2006		Report Date:	02/06/2006
Licensee/Reporting Party Inf	ormati	on:						
Agreement State Regulated:	YS			Reciprocity:	NONE			
License Number:	TN-R-	47080		Name:	CARDINAL HEA	ALTH	ł	
NRC Docket Number:	NA			City:	KNOXVILLE			
NRC Program Code:	NA			State: TN	Zip Code: 3792	1		
Responsible NRC Region:	1							
Site of Event:								
Site Name: KNOXVILLE								
State: TN								
Additional Involved Party:								
License Number:	NR			Name:	NR			
NRC Docket Number:	NR			City:	NR			
NRC Program Code:	NR			State: NR	Zip Code: NR			
Responsible NRC Region:	NR							
Other Information:								
NRC Reportable Event:		Ν		Abnormal O	ccurrence:	Ν	١	
Agreement State Reportable	Event:	Y		Investigation	ו:	Ν	٨	
Atomic Energy Act Material:		Y		NMED Reco	ord Complete:	Y	(
Consultant Hired:		N		Event Close	ed by Region/Stat	te: Y	(

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR Old Cause: WRONG VIAL SELECTED WHEN DRAWING DOSE

Corrective Actions Information:

Action Number: Corrective Action:

MD2

1 PROCEDURE MODIFIED

2 PERSONNEL REPRIMANDED

Patient Number: 1 Patient Informed: U Date Informed: Given: Diagnostic Study: HEPATOBILIARY Radiopharmaceutical: MEBROFENIN/CHOLETECH Radiopharmaceutical: MEBROFENIN/CHOLETECH Radiopharmaceutical: MEBROFENIN/CHOLETECH Radiopharmaceutical: MEBROFENIN/CHOLETECH Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI Radionuclide: TC-99M Ó Dose Exceeds Prescribed: NA % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA % Dose is Less Than Prescribed: NA % Dose is Less Than Prescribed: NA % Dose for addiation: MD2 Source of Radiation: MD2 MD2 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: NR Ci NR GBg Model Number: NA Activity: NR Ci NR GBg Model Number: NA Activity: NR Ci NR GBg Model Number: NA Activit						
Given: Diagnostic Study: HEPATOBILIARY Radiopharmaceutical: MEBROFENIN/CHOLETECH Radionuclide: TC-99M Activity: NR mCi NR MEq Intended: Diagnostic Study: RENAL BLOOD FLOW Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI Radionuclide: TC-99M Activity: NR mCi NR MEq % Dose Exceeds Prescribed: NA % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NR <	Patient Number: 1					
Diagnostic Study: HEPATOBILIARY Radiopharmaceutical: MEBROFENIN/CHOLETECH Radionuclide: TC-99M Activity: NR mCi NR MBq Intended: Diagnostic Study: RENAL BLOOD FLOW Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI Radionuclide: TC-99M Activity: NR mCi NR MBq % Dose Exceeds Prescribed: NA % Dose Exceeds Prescribed: NA Effect on Patient: Source of Radiation: HD2 Source Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Code Initials: Reference Type:	Patient Informed: U	Date Informed:				
Radiopharmaceutical: MEBROFENIN/CHOLETECH Radionuclide: TC-99M Activity: NR mCi NR MBq Intended: Diagnostic Study: RENAL BLOOD FLOW Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI Radionuclide: TC-99M Activity: NR mCi NR MBq % Dose Exceeds Prescribed: NA Activity: NR mCi NR MBq % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2 Source Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR MA Activity: NR GBq Model Number: NA Activity: NR GBq References: Reference Number: NA	Given:					
Radionuclide: TC-99M Activity: NR mCi NR MBq Intended: Diagnostic Study: RENAL BLOOD FLOW Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI NR mCi NR MBq % Dose Exceeds Prescribed: NA % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribe: NR Manufacturer: NR Model Number: NA % Serial Number: NA % Refe	Diagnostic Study:	HEPATOBILIARY				
Intended: Diagnostic Study: RENAL BLOOD FLOW Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI Radionuclide: TC-99M Activity: NR mCi ND ose Exceeds Prescribed: NA % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: AD2 Source/Radioactive Material: Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Serial Number: NA References References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Radiopharmaceutical:	MEBROFENIN/CHOLETECH	I			
Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI Radionuclide: TC-99M Activity: NR mCi NR MBq % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribe	Radionuclide: TC-99	M Activity:	NR mCi	NR MBq		
Radiopharmaceutical: MAG3 (MERCAPTO ACETYL TRIGLYCI Radionuclide: TC-99M Activity: NR mCi NR MBq % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA % Dose is Less Than Prescribed: NA % Dose is Less Than Prescribed: NA Source of Radiation:	Intended:					
Radionuclide: TC-99M Activity: NR mCi NR MBq % Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Activity: NR Ci NR GBq Model Number: NA Activity: NR Ci NR GBq References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Diagnostic Study:	RENAL BLOOD FLOW				
% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Serial Number: NA References: References Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Radiopharmaceutical:	MAG3 (MERCAPTO ACETYL	- TRIGLYCI			
% Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2 Model Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Radionuclide: TC-99	M Activity:	NR mCi	NR MBq		
Effect on Patient: Source of Radiation: MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Serial Number: NA References: References Intry Date: Retraction Date: Coder Initials: Reference Type:	% Dose Exceeds Pres	cribed: NA				
Source of Radiation: MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Serial Number: NA References: References Intry Date: Retraction Date: Coder Initials: Reference Type:	% Dose is Less Than F	Prescribed: NA				
MD2 Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Effect on Patient:					
Source Number: 1 Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	ource of Radiation:					
Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	1D2					
Manufacturer: NR Activity: NR Ci NR GBq Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:		-				
Model Number: NA Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Number: Entry Date: Retraction Date:			RADIOPHARM	Radionuclide or Volta		
Serial Number: NA References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:		NR		Activity:	NR Ci	NR GBq
References: Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Model Number:	NA				
Reference Number: Entry Date: Retraction Date: Coder Initials: Reference Type:	Serial Number:	NA				
	References:					
TN06022 07/18/2006 DCH AGREEMENT STATE EVENT REPORT		•				
	TN06022	07/18/2006	DCH	AGREEMENTS	STATE EVENT REPORT	

Narrative:

The licensee reported that a patient who was not scheduled to receive any radioactive material received 0.93 GBq (25 mCi) of Tc-99m medronate . The technician failed to follow protocol and did not check the patient's name and birth date. The licensee stated that patients need to wear arm tags and the technician needs to verify the proper patient has been presented.

Event Da	ate: 01/17/2006	Discovery Date:	01/17/2006	Report Date:	01/24/2006
Licensee/Reporting Party In	formation:				
Agreement State Regulated	: YS	Reciprocity:	NONE		
License Number:	TN-R-79104	Name:	SAINT FRANCIS	HOSPITAL	
NRC Docket Number:	NA	City:	MEMPHIS		
NRC Program Code:	NA	State: TN	Zip Code: 38119		
Responsible NRC Region:	1				
Site of Event:					
Site Name: MEMPHIS					
State: TN					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal O	ccurrence:	Ν	
Agreement State Reportable	e Event: Y	Investigation	1:	Ν	
Atomic Energy Act Material:	Y	NMED Reco	ord Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State:	Y	
Event Type:					
MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
Cause: FAILURE TO F	OLLOW PROCEDU	RE OR WRONG PROCE	DURE USED		
Old Cause: WRONG PATIE	ENT SELECTED				
Corrective Actions Informat	ion:				
Action Number: Corrective	e Action:				

925 MBq

Action Number: Corrective Action:

MD2

1 PERSONNEL RECEIVED ADDITIONAL TRAINING

Patient Information:

Patient	Number:	1
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Patient Informed: Y Da	ate Informed: 01/17/2006
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Given:

Diagnostic Study: BONE SCAN

Radiopharmaceutical: MEDRONATE

Radionuclide:	TC-99M	Activity:	25 mCi	

Intended:

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2

Source Number:	1					
Source/Radioactive Mat	terial: UNSEAL	ED SOURCE RADIO	PHARM Ra	dionuclide or Voltage (k	Vp/MeV): TC-99M	
Manufacturer:	NR		Ac	tivity:	0.025 Ci	0.925 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
TN06011	07/17/2006		DCH	AGREEMENT STAT	TE EVENT REPORT	

Narrative:

Deka b Baptist Medical Center reported that a patient received the wrong radiopharmaceutical. The Medical Center ordered a 185 MBq (5 mCi) Tc-99m choletec dose from the licensee. The dose received was labeled as choletec, but when administered to the patient, the resulting scan primarily showed uptake by the kidneys. An investigation by the licensee revealed that the dose was mistakenly dispensed as Tc-99m MAG-3. The root cause was determined to be a failure of the pharmacist to properly select the drug for the dose in question. The licensee has many extra verification steps to be performed prior to dispensing, which must have also been skipped or performed incorrectly. Corrective actions taken by the licensee included holding an in-service meeting and adding an additional dispensing process to ensure further accuracy.

Event Dat	e:	05/11/2006	Discovery Date:	05/11/2006	Report Date:	05/27/2006
Licensee/Reporting Party Inf	orma	tion:				
Agreement State Regulated:	YS		Reciprocity	NONE		
License Number:	AL-1	168	Name:	CARDINAL HEALT	Ή	
NRC Docket Number:	NA		City:	BIRMINGHAM		
NRC Program Code:	NA		State: AL	Zip Code: 35233		
Responsible NRC Region:	1					
Site of Event:						
Site Name: BIRMINGHAM						
State: AL						
Additional Involved Party:						
License Number:	NR		Name:	DEKALB BAPTIST	MEDICAL CENTER	र
NRC Docket Number:	NR		City:	FORT PAYNE		
NRC Program Code:	NR		State: AL	Zip Code: NR		
Responsible NRC Region:	1					
Other Information:						
NRC Reportable Event:		Ν	Abnormal C	Occurrence:	Ν	
Agreement State Reportable	Even	t: Y	Investigatio	n:	Ν	
Atomic Energy Act Material:		Y	NMED Rec	ord Complete:	Y	
Consultant Hired:		Ν	Event Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT

Event Cause:

MD2

Cause: FAILURE TO FOLLOW PROCEDURE OR WRONG PROCEDURE USED

Old Cause: SYRINGE MISLABELED

Corrective Actions Information:

Action Number: Corrective Action:

MD2

- 1 PROCEDURE MODIFIED
- 2 PERSONNEL RECEIVED ADDITIONAL TRAINING

Detient Number: 4					
Patient Number: 1		0			
Patient Informed: Y	Date Informed: 05/11/2006	6			
Given:					
Diagnostic Study:	RENAL-TUBULAR SECRETION (MA	(G3)			
Diagnootio otaaji					
Radionharmaceutical:	MAG3 (MERCAPTO ACETYL TRIGL	YCI			
Radionuclide: TC-99			185 MBq		
	norviy.				
Intended:					
Diagnostic Study:	HEPATOBILIARY				
Diagnostio Otady.					
Radionharmaceutical:	MEBROFENIN/CHOLETECH				
radiopharmaceutoal.					
% Dose Exceeds Prese	cribed: NA				
% Dose is Less Than F	Prescribed: NA				
Effect on Patient:					
Source of Radiation:					
MD2					
Source Number:	1				
Source/Radioactive Ma	aterial: UNSEALED SOURCE RADIO	PHARM Radio	onuclide or Voltage (kVp	/MeV): TC-99M	
Manufacturer:	NR	Activ	ity:	0.005 Ci	0.185 GBq
Model Number:	NA				
Serial Number:	NA				
Device/Associated Equi	ipment:				
MD2					
Device Number: 1					
Device Name: SY	RINGE	Mode	el Number: NA	L Contraction of the second seco	
Manufacturer: NF	र	Seria	I Number: NA	L Contraction of the second seco	
References:					
Reference Number:	Entry Date: Retraction Date:	Coder Initials:	Reference Type:		
AL060024	06/16/2006	DCH	AGREEMENT STATE	EVENT REPORT	
, (200024	00,10,2000	DOIT			

Last Updated: 06/11/2007

Narrative:

The licensee reported that a 64-year-old male outpatient received an 81.4 MBq (2.2 mCi) dose of I-131 instead of the intended 3.7 MBq (100 uCi) dose. The patient's referring physician ordered a thyroid scan to evaluate an enlarged thyroid lobe. The licensee's protocol is to administer 3.7 MBq (100 uCi) of I-131 to a patient with an intact thyroid gland. However, the licensee's central scheduling staff modified the written order to indicate that the patient should receive a metastatic thyroid scan, implying that the patient did not have an intact thyroid. The licensee's protocol for a metastatic scan requires the administration of 74 MBq (2 mCi) of I-131. So, the written order conflicted with the patient's symptoms as indicated on the order (a metastatic thyroid scan for an enlarged lobe). Licensee personnel failed to question the conflict and administered 81.4 MBq (2.2 mCi) of I-131 to the patient on 6/12/2006. The patient returned on 6/14/2006 for a whole body scan, which indicated an intact thyroid gland with significant I-131 uptake and resulted in the discovery that the patient had received the wrong procedure. The estimated dose to the patient's thyroid was 3,300 cSv (rem). The licensee concluded that this event would not result in adverse health consequences for the patient. The root cause of this event was human error involving the failure to verify the status of the patient's thyroid prior to the administration. Corrective actions included personnel retraining and procedure modification to include verification that a patient's thyroid has been removed whenever a metastatic thyroid scan is ordered. An NRC inspection concluded that no medical event occurred because the licensee followed their protocol for the type of exam that had been scheduled and the written directive was followed.

Event Da	te: 0	6/12/2006	Discovery	Date:	06/14/2006	Report Date:	06/14/2006
Licensee/Reporting Party In	formati	ion:					
Agreement State Regulated:	NO		Recip	rocity:	NONE		
License Number:	21-01	354-04	Name	:	BATTLE CREEK H	IEALTH SYSTEM	
NRC Docket Number:	03013	3899	City:		BATTLE CREEK		
NRC Program Code:	02120)	State:	MI	Zip Code: 49016		
Responsible NRC Region:	3						
Site of Event:							
Site Name: BATTLE CREE	K						
State: MI							
Additional Involved Party:							
License Number:	NA		Name	:	NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State:	NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abnor	mal C	occurrence:	Ν	
Agreement State Reportable	Event	N	Invest	igatio	n:	Y	
Atomic Energy Act Material:		Y	NME	Reco	ord Complete:	Y	
Consultant Hired:		Ν	Event	Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT

Event Cause:

MD2

Cause: HUMAN ERROR

Old Cause: RADIOPHARMACEUTICAL OR DOSE ORDER MISUNDERSTOOD

Corrective Actions Information:

Action Number: Corrective Action:

MD2

- 1 PERSONNEL RECEIVED ADDITIONAL TRAINING
- 2 PROCEDURE MODIFIED

Patient Number: 1							
Patient Informed: Y	Date	Informed:					
Given:							
Therapeutic Procedure	: SODIUM IODI	DE - T					
Organ:	THYROID						
Radiopharmaceutical:	SODIUM IODI	DE					
Radionuclide: I-131		Activity:	2.2 mCi	81.4 MBq	Dose:	3300 rad	33 Gy
Intended:							
Therapeutic Procedure	: SODIUM IODI	DE - T					
Organ:	THYROID						
Radiopharmaceutical:	SODIUM IODI	DE					
Radionuclide: I-131		Activity:	0.1 mCi	3.7 MBq	Dose:	NR rad	NR Gy
% Dose Exceeds Pres	cribed: 21	00					
% Dose is Less Than F							
Effect on Patient:	Tescribed. INF	N Contraction of the second se					
Source of Radiation:							
MD2							
Source Number:	1						
Source/Radioactive Ma	-			tionuclide or		Vp/MeV): I-131	
Manufacturer:	NR			ivity:	vollage (k	0.0022 Ci	0.0814 GBg
Model Number:	NA		Acti	vity.		0.0022 Ci	0.0014 GBq
Serial Number:	NA						
Senai Number.							
References:							
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference	e Type:		
EN42639	06/15/2006		DCH	EVENT N	IOTIFICATI	ION	
LTR060724	07/31/2006		RLS	NRC LET	TER		
ML061990623	07/31/2006		RLS	INSPECT	ION REPC	RT	
ML061990623	07/31/2006		RLS	NRC LET	TER		
ML062340380	09/20/2006		RLS	LICENSE	EREPOR	Г	
ML062550235	09/20/2006		RLS	NRC LET	TER		
ML062550264	09/20/2006		RLS	ADAMS [DOCUMEN	T PACKAGE	
ML071580957	06/11/2007		RLS	INSPECT	ION REPC	RT	

Last Updated: 06/04/2007

Narrative:

The licensee reported administering a dose that was 4% higher than the prescribed dose during a brachytherapy prostate treatment. The intent was to deliver a 14,500 cGy (rad) dose using permanently implanted I-125 seeds (Best model 2301). The licensee ordered seeds with an activity of 12.58 MBq (0.34 mCi) per seed. A computer was used to determine the number of seeds needed to deliver the intended dose based on the activity per seed. The staff incorrectly entered the activity per seed as "0.34 U" rather than "0.34 mCi". The symbol U is for airkerma strength. Therefore, the computer calculated the seed activity as 9.92 MBq (0.268 mCi) instead of 12.58 MBq (0.34 mCi), a difference of 27%. As a result, the computer calculated a quantity of 100 seeds to be used. The error in the calculation was not discovered until after the implant was performed. Although the implanted source activity was 27% higher than intended, calculations based on a post-implant dosimetry CT scan showed a D90 (the minimum dose received by 90% of the prostate volume) of 15,077 cGy (rad), which is 104% of the prescribed dose. The NRC contracted a medical consultant, who determined that no significant impact is expected as a result of this event. The licensee performed an audit of recent prostate implant cases and identified one other event that occurred on 5/30/2006 involving accelerator-produced Pd-103. This event was reported to the State of Delaware. To prevent recurrence, the licensee modified procedures to verify the correct radionuclide and source strength.

Event Da	t e: 0	6/12/2006	Discover	y Date	06/12/2006	Report Date:	06/12/2006
Licensee/Reporting Party Inf	formati	on:					
Agreement State Regulated:	NO		Reci	procity	NONE		
License Number:	07-14	850-01	Nam	e:	BAYHEALTH MED	ICAL CENTER	
NRC Docket Number:	03007	565	City:		DOVER		
NRC Program Code:	02120)	State	: DE	Zip Code: 19901		
Responsible NRC Region:	1						
Site of Event:							
Site Name: DOVER							
State: DE							
Additional Involved Party:							
License Number:	NA		Nam	e:	NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State	e: NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abno	ormal C	Occurrence:	Ν	
Agreement State Reportable	Event:	Ν	Inve	stigatio	n:	Y	
Atomic Energy Act Material:		Y	NME	D Rec	ord Complete:	Υ	
Consultant Hired:		Y	Ever	t Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR Old Cause: COMPUTER TREATMENT PLANNING SOFTWARE ERROR Corrective Actions Information: Action Number: Corrective Action: MD2

1 PROCEDURE MODIFIED

Patient Number: 1								
Patient Informed: Y	Date	Informed: 0	6/12/2006					
Talient morned. T	Date	inionnea. o	0/12/2000					
Given:								
Therapeutic Procedure		UAL IMPLA	NT					
Organ:	PROSTATE							
Radiopharmaceutical:	NA							
Radionuclide: I-125		Activity:	34 r	nCi	258 MBq	Dose:	15077 rad	150.77 Gy
Intended:								
Therapeutic Procedure	E BRACHY, MAN	UAL IMPLAI	NT					
Organ:	PROSTATE							
Radiopharmaceutical:	NA							
Radionuclide: I-125		Activity:	26.8 r	nCi 9	91.6 MBq	Dose:	14500 rad	145 Gy
% Dose Exceeds Prese	cribed: 4							
% Dose is Less Than F	Prescribed: NA							
Effect on Patient:								
Source of Radiation:								
MD2								
Source Number:	1							
Source/Radioactive Ma			RACHYTHEF			Voltage (k)	/p/MeV): I-128	5
Manufacturer:		DUSTRIES		Acti	vity:		0.034 Ci	1.258 GBq
Model Number:	2301							
Serial Number:	AGGREG	IATE						
References:								
Reference Number:	Entry Date:	Retraction		oder Initials:	Reference			
EN42634	06/13/2006			СН	EVENT NO			
ML061720263	08/10/2006			LS	LICENSE	EREPORT		
ML061720263	08/10/2006			LS	OTHER			
ML062220095	08/22/2006			LS	INSPECTI			
ML062220095	08/22/2006			LS	NOTICE C		ION	
ML062220095	08/22/2006			LS	NRC LET			
LTR061026	10/31/2006			СН	NRC LET			
ML062130112	06/04/2007			СН	LICENSE			
ML062130112	06/04/2007		D	СН	REGION F	REPORT		

Source of Radiation:

Last Updated: 07/13/2006

Narrative:

The licensee reported that a patient received 0.15 GBq (4 mCi) of TI-201 instead of the prescribed dose of Tc-99m pertechnetate. The administration resulted in a whole body dose of 5.2 cSv (rem). The patient, authorized user, and referring physican were notified of the error and the correct radiopharmaceutical was administered. The licensee's RSO conducted an investigation and interviewed persons involved with the administration. The cause of the incident was identified as inattention to labeling on the part of the technician. Remedial instruction was given to the technician. The State of New Hampshire is tracking the event as number NH060001.

was given to the technician. T	he State of New Hampsh	nire is tracking the	event as number	NH060001.	
Event Date:	03/03/2006	Discovery Date:	03/03/2006	Report Date:	03/07/2006
Licensee/Reporting Party Infor Agreement State Regulated: Y License Number: N NRC Docket Number: N	mation: ′S IH-130R IA IA	Reciprocity: Name: City:	NONE	Report Date: CK MEMORIAL HO	
License Number: N	IA	Name:	NA		
NRC Docket Number: N	IA	City:	NA		
NRC Program Code: N	IA	State: NA	Zip Code: NA		
Responsible NRC Region: N	A				
Other Information:					
NRC Reportable Event:	Ν	Abnormal Oc	ccurrence:	Ν	
Agreement State Reportable E	vent: Y	Investigation		Y	
Atomic Energy Act Material:	Y		rd Complete:	Y	
Consultant Hired:	Ν	Event Closed	d by Region/State:	Y	
Event Cause: MD2 Cause: INATTENTION TC Old Cause: INATTENTION TC Corrective Actions Information Action Number: Corrective A MD2 1 PERSONNE) DETAIL I:	IAL TRAINING			
Patient Information:					
Patient Number: 1					
Patient Informed: Y	Date Informed:				
Given:					
Diagnostic Study: NR					
Radiopharmaceutical: THALI Radionuclide: TL-201	LOUS CHLORIDE Activity:	4 mCi	148 MBq		
Intended: Diagnostic Study: NR					
Radiopharmaceutical: SPER Radionuclide: TC-99M	T/PERT (PERTECHNET) Activity:	ATE-TCO4 NR mCi	NR MBq		
% Dose Exceeds Prescribed: % Dose is Less Than Prescrib Effect on Patient:	NA ed: NA				

MD2						
Source Number:	1					
Source/Radioactive M	aterial: UNSEAL	ED SOURCE RADIO	PHARM F	Radionuclide or Volt	age (kVp/MeV): TL-201	
Manufacturer:	NR		Α	ctivity:	0.004 Ci	0.148 GBq
Model Number:	NA					
Serial Number:	NA					
Device/Associated Equ	ipment:					
MD2						
Device Number: 1						
Device Name: S'	YRINGE		N	lodel Number:	NA	
Manufacturer: N	R		S	erial Number:	NA	
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials	: Reference Ty	pe:	
EN42440	03/27/2006		DCH	EVENT NOTIF AGREEMENT	FICATION REPORTED FR	OM AN
LTR060713	07/13/2006		DCH	AGREEMENT	STATE LETTER	

Narrative:

The licensee reported that a technician at Saint Francis North Hospital informed them that a scan on a patient had shown lung imaging instead of the expected cardiac imaging. An investigation revealed that the hospital's myoview dose for cardiac imaging had mistakenly been dispensed as a 0.37 GBq (10 mCi) Tc-99m MAA dose, which is for lung imaging. The cause of the event was determined to be the failure by the dispensing pharmacist to follow proper licensee compounding procedures. The pharmacist pulled the wrong kit from the refrigerator. The pharmacist performed a QC test on the dose, but failed to label the starting point on the QC chromatography strip, which led to a misinterpretation of the failing test as a passing test. In order to prevent a recurrence of this event, the licensee is going to begin requiring all employees performing QC tests to label the starting point of all QC strips. Also, the licensee is planning to switch brands of MAA since the Drax MAA vials and the myoview vials are identical in appearance.

Event Dat	te: (03/05/2006	Discovery Date:	03/05/2006	Report Date:	03/07/2006
Licensee/Reporting Party Inf	ormat	ion:				
Agreement State Regulated:	YS		Reciprocity:	NONE		
License Number:	LA-5	119-L01	Name:	CARDINAL HEALT	ГН	
NRC Docket Number:	NA		City:	WEST MONROE		
NRC Program Code:	NA		State: LA	Zip Code: 71292		
Responsible NRC Region:	4					
Site of Event:						
Site Name: MONROE						
State: LA						
Additional Involved Party:						
License Number:	NR		Name:	SAINT FRANCIS N	NORTH HOSPITAL	
NRC Docket Number:	NR		City:	MONROE		
NRC Program Code:	NR		State: LA	Zip Code: 71201		
Responsible NRC Region:	4					
Other Information:						
NRC Reportable Event:		Ν	Abnormal C	occurrence:	Ν	
Agreement State Reportable	Event	: Y	Investigation	n:	Ν	
Atomic Energy Act Material:		Y	NMED Reco	ord Complete:	Y	
Consultant Hired:		N	Event Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: FAILURE TO FOLLOW PROCEDURE OR WRONG PROCEDURE USED Old Cause: SYRINGE MISLABELED Corrective Actions Information: Action Number: Corrective Action: MD2 1 NEW PROCEDURE WRITTEN

Patient Number:	1						
Patient Informed: Y	Z Dat	e Informed: 03/05	5/2006				
Given:							
Diagnostic Study:	LUNG PERFL	JSION					
Radiopharmaceutic	al: MAA (MACRO	DAGGREGATED	ALBUMIN)				
Radionuclide: TC	-99M	Activity:	10 mCi	370 ME	q		
Intended:							
Diagnostic Study:	CARDIAC						
Radiopharmaceutic	al: MYOVIEW						
Radionuclide: TC	-99M	Activity:	10 mCi	370 ME	q		
Source of Radiation MD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number:	1	LED SOURCE R	ADIOPHARM	Radionuclid Activity:	e or Voltage (k	Vp/MeV): TC-99M 0.01 Ci	
AD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated E	1 Material: UNSEA NR NA NA	LED SOURCE R/	ADIOPHARM		e or Voltage (k		1 0.37 GBq
MD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number:	1 Material: UNSEA NR NA NA	LED SOURCE R	adiopharm		e or Voltage (k		
AD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated E AD2	1 Material: UNSEA NR NA NA Equipment:	ALED SOURCE R/	ADIOPHARM				
AD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated E AD2 Device Number:	1 Material: UNSEA NR NA NA Equipment:	LED SOURCE R	ADIOPHARM	Activity:	per:	0.01 Ci	
AD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number: Serial Number: Device/Associated E AD2 Device Number: Device Name:	1 Material: UNSEA NR NA NA Squipment:	LED SOURCE R/	ADIOPHARM	Activity: Model Numl	per:	0.01 Ci NA	
MD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated E MD2 Device Number: Device Name: Manufacturer:	1 Material: UNSEA NR NA NA Equipment: 1 SYRINGE NR	LED SOURCE R		Activity: Model Numl Serial Numb	per:	0.01 Ci NA	
MD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number: Serial Number: Device/Associated E MD2 Device Number: Device Name: Manufacturer: References:	1 Material: UNSEA NR NA NA Equipment: 1 SYRINGE NR			Activity: Model Numł Serial Numł itials: Refer EVEN	per: ler: ence Type:	0.01 Ci NA NA ION REPORTED FF	0.37 GBq
MD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number: Device/Associated E MD2 Device Number: Device Name: Manufacturer: References: Reference Numbe	1 Material: UNSEA NR NA Squipment: 1 SYRINGE NR r: Entry Date:		ate: Coder In	Activity: Model Numł Serial Numł itials: Refer EVEN AGRE	per: ler: ence Type: T NOTIFICAT	0.01 Ci NA NA ION REPORTED FF 'E	0.37 GBq
MD2 Source Number: Source/Radioactive Manufacturer: Model Number: Serial Number: Serial Number: Device/Associated E MD2 Device Number: Device Name: Manufacturer: References: Reference Numbe EN42418	1 Material: UNSEA NR NA Squipment: 1 SYRINGE NR r: Entry Date: 03/20/2006		ate: Coder In DCH	Activity: Model Numl Serial Numb itials: Refer EVEN AGRE AGRE	per: er: ence Type: T NOTIFICAT EMENT STAT EMENT STAT	0.01 Ci NA NA ION REPORTED FF 'E	0.37 GBq ROM AN

Narrative:

The licensee initially reported that a patient scheduled to receive 0.15 GBq (4 mCi) of I-131 for a whole body scan received a therapy dose of 7.4 GBq (200 mCi) of I-131. It was later determined that the patient had received the scheduled 0.15 GBq (4 mCi) of I-131 for a whole body scan. The patient returned to the licensee's facility on 1/16/2006 and was scanned. The board certified nuclear medicine physician assigned to the case as the authorized user reviewed the scan and, using his professional judgment, determined that a therapy dose was medically indicated. The authorized user generated a written directive, obtained a dose of 7.4 GBq (200 mCi) of I-131, and administered it to the patient on 1/16/2006. During the licensee investigation, the RSO obtained copies of documents that verified this dose was ordered and administered in full compliance with regulations and conditions. Unfortunately, the referring physician assumed that the therapy dose had been administered instead of the whole body scan dose and mistakenly reported that a medical event had occurred.

Event Dat	te: 0 ⁻	1/16/2006	Discovery Date	02/02/2006	Report Date:	02/03/2006
Licensee/Reporting Party Inf	formatio	on:				
Agreement State Regulated:	YS		Reciprocity	NONE		
License Number:	SC-00	80	Name:	MEDICAL UNIVER	RSITY OF SOUTH	CAROLINA
NRC Docket Number:	NA		City:	CHARLESTON		
NRC Program Code:	NA		State: SC	Zip Code: 29425		
Responsible NRC Region:	1					
Site of Event:						
Site Name: CHARLESTON						
State: SC						
Additional Involved Party:						
License Number:	NA		Name:	NA		
NRC Docket Number:	NA		City:	NA		
NRC Program Code:	NA		State: NA	Zip Code: NA		
Responsible NRC Region:	NA					
Other Information:						
NRC Reportable Event:		Ν	Abnormal C	Occurrence:	Ν	
Agreement State Reportable	Event:	Y	Investigatio	n:	Υ	
Atomic Energy Act Material:		Y	NMED Rec	ord Complete:	Y	
Consultant Hired:		Ν	Event Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: COMMUNICATION PROBLEM Old Cause: REFERRING PHYSICIAN'S REQUEST MISUNDERSTOOD Corrective Actions Information: Action Number: Corrective Action: MD2

1 NO CORRECTIVE ACTION TAKEN

Patient Number: 1 Patient Informed: Y	Date	Informed:						
r allent mormed.	Date	intorneu.						
Given:								
Therapeutic Procedure		E - T						
Organ:	THYROID							
Radiopharmaceutical:	SODIUM IODID	E						
Radionuclide: I-131		Activity:	200 mCi	7	400 MBq	Dose:	NR rad	NR Gy
Intended:								
Therapeutic Procedure	SODIUM IODID	E - T						
Organ:	THYROID							
Radiopharmaceutical:	SODIUM IODID	E						
Radionuclide: I-131		Activity:	200 mCi	7	400 MBq	Dose:	NR rad	NR Gy
% Dose Exceeds Preso	ribed: NA							
% Dose is Less Than F	rescribed: NA							
Effect on Patient:								
ource of Radiation:								
1D2								
Source Number:	1							
Source/Radioactive Ma	terial: UNSEALI	ED SOURCE RAD	IOPHARM	Radi	onuclide or	Voltage (kVp/	MeV): I-131	
Manufacturer:	NR			Activ	vity:		0.2 Ci	7.4 GBq
Model Number:	NA							
Serial Number:	NA							
References:								
Reference Number:	Entry Date:	Retraction Date	e: Coder Init	ials:	Reference	е Туре:		
EN42306	02/08/2006		DCH			OTIFICATION ENT STATE	REPORTED FR	OM AN
SC060003	02/23/2006		DCH		AGREEM	ENT STATE E	EVENT REPORT	

Narrative:

The licensee reported that a patient was administered 151.7 MBq (4.1 mCi) of I-131 for a diagnostic whole body scan without a written directive. The patient had a physician's order to perform the scan, but the technologists over-looked the fact that there was no written directive. The patient received the correct dose of I-131 for his scan. Corrective actions included re-training all nuclear medicine technologists on the requirement to have a signed written directive prior to ordering or administering I-131. The event was retracted on 1/19/2006 based on discussions with NRC personnel because this event did not meet the criteria for a medical event.

1/19/2006 based on discuss	sions with NRC personnel be	ecause this ever	nt did not meet the o	riteria for a medica	event.
Event Da	te: 01/11/2006 I	Discovery Date	: 01/11/2006	Report Date:	01/12/2006
Licensee/Reporting Party Inf	formation:				
Agreement State Regulated:	NO	Reciprocity	: NONE		
License Number:	06-02388-01	Name:	NEW BRITAIN GE	ENERAL HOSPITA	L
NRC Docket Number:	03001250	City:	NEW BRITAIN		
NRC Program Code:	02230	State: CT	Zip Code: 06050		
Responsible NRC Region:	1				
Site of Event:					
Site Name: NEW BRITAIN					
State: CT					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	,	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal (Occurrence:	Ν	
Agreement State Reportable	Event: N	Investigatio	on:	Y	
Atomic Energy Act Material:	Y	-	cord Complete:	Y	
Consultant Hired:	Ν		ed by Region/State:	Ν	
Old Cause: PROCEDURE N Corrective Actions Informati Action Number: Corrective MD2	on:		EDURE USED		
Patient Information:					
Patient Number: 1	Data Informadi				
Patient Informed: U	Date Informed:				
Given:					
Diagnostic Study: WH	OLE BODY I-131/THYROID				
Radiopharmaceutical: SOI					
Radionuclide: I-131	Activity:	4.1 mCi	151.7 MBq		
	2				
Intended:					
A thorapoutic procedure/dia	anostic study was not intend	od			

A therapeutic procedure/diagnostic study was not intended.

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation:

MD2

Source Nu	mber: 1				
Source/Rad	dioactive Material:	UNSEALED SOURCE RADIOPHARM	Radionuclide or Voltage (kVp/	/MeV): I-131	
Manufactur	er:	NR	Activity:	0.0041 Ci	0.1517 GBq
Model Num	iber:	NA			
Serial Num	ber:	NA			

References:

Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:
EN42253	01/13/2006	01/19/2006	DCH	EVENT NOTIFICATION
LTR040603	01/16/2006		DCH	NRC LETTER
ML070820100	03/26/2007		RLS	INSPECTION REPORT
ML070820070	04/06/2007		RLS	ADAMS DOCUMENT PACKAGE
ML070860843	04/06/2007		RLS	LICENSEE REPORT

Narrative:

The licensee reported dispensing a dose of Tc-99m MAG3 that was labeled as Tc-99m MAA to Huntsville Hospital. A patient that was scheduled for a lung scan was administered the MAG3 dose. When scanned, the technologist noticed little lung uptake, but did notice some uptake in the lung and stomach. Investigation determined that the licensee pharmacist had incorrectly placed a MAG3 vial in a MAA labeled vial shield, causing the error. Once the error was discovered, other customers who received doses from the same vial were notified and advised to discard the doses.

advised to discard the doses.					
Event Date:	09/02/2005 Dis	scovery Date:	09/02/2005	Report Date:	10/08/2005
Licensee/Reporting Party InformAgreement State Regulated:YSLicense Number:AlNRC Docket Number:NLNRC Program Code:NLResponsible NRC Region:1	S L-1068 A A		NONE CARDINAL HEALT HUNTSVILLE Zip Code: NR	ГН	
Site of Event: Site Name: HUNTSVILLE State: AL					
Additional Involved Party:License Number:NiNRC Docket Number:NiNRC Program Code:NiResponsible NRC Region:1	R R	Name: City: State: AL	HUNTSVILLE HOS HUNTSVILLE Zip Code: NR	SPITAL	
Other Information: NRC Reportable Event: Agreement State Reportable Ev Atomic Energy Act Material: Consultant Hired:	vent: Y Y N			N Y Y Y	
	ELED :	TRAINING			
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed: 09/02/20	005			
Given: Diagnostic Study: NR					
Radiopharmaceutical: MAG3 Radionuclide: TC-99M	(MERCAPTO ACETYL TRIC Activity:	GLYCI NR mCi	NR MBq		
Intended: Diagnostic Study: LUNG	PERFUSION				
Radiopharmaceutical: MAA (N	MACROAGGREGATED AL	BUMIN)			

% Dose Exceeds Prescribed:NA% Dose is Less Than Prescribed:NAEffect on Patient:X

Source of Radiation:					
MD2					
Source Number: 1					
Source/Radioactive Material:	UNSEALED SOURCE RADIOP	PHARM Radio	onuclide or Voltage (kV	p/MeV): TC-99M	
Manufacturer:	NR	Activi	ity:	NR Ci	NR GBq
Model Number:	NA				
Serial Number:	NA				
Device/Associated Equipmen	t:				
MD2					
Device Number: 1					
Device Name: SYRING	Ξ	Mode	el Number: N	A	
Manufacturer: NR		Seria	l Number: N	A	
References:					
	y Date: Retraction Date: 6/2005	Coder Initials: DCH	Reference Type: AGREEMENT STATE	EVENT REPORT	

Narrative:

The licensee reported that the wrong patient received 0.37 GBq (10 mCi) of Tc-99m cardiolite. The patient prescribed to receive the cardiac stress test was in the waiting room with another patient that had the same last name and a rhyming first name. The intended patient's name was called and the wrong patient answered the call. The patient's name and date of birth were not verified prior to administration. The individual was notified as soon as it was realized. Licensee staff will verify the patient's name and date of birth prior to administration.

		icensee stan will ver	ily the patient's ha	ine and date of birth	n prior to administration.
Event Dat	te: 04/06/2005	Discovery Date:	04/06/2005	Report Date:	04/06/2005
_icensee/Reporting Party Inf	formation:				
Agreement State Regulated:	YS	Reciprocity:	NONE		
License Number:	TN-R-57032	Name:	THE JACKSON (CLINIC	
NRC Docket Number:	NA	City:	JACKSON		
NRC Program Code:	NA		Zip Code: 38301		
Responsible NRC Region:	1		P		
Site of Event:					
Site Name: JACKSON					
State: TN					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal O	ccurrence:	Ν	
Agreement State Reportable	Event: Y	Investigation	Investigation:		
Atomic Energy Act Material:	Y	NMED Reco	ord Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State	e: Y	
Old Cause: WRONG PATIE Corrective Actions Informati Action Number: Corrective MD2	on:	ONAL TRAINING	DURE USED		
	RDIAC SCAN				
Radiopharmaceutical: SES Radionuclide: TC-99M	Activity:	10 mCi	370 MBq		
	Activity.				

% Dose Exceeds Prescribed: NA % Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2

Source Number:	1						
Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM			PHARM Rad	Radionuclide or Voltage (kVp/MeV): TC-99M			
Manufacturer:	NR		Acti	vity: 0.01 Ci	0.37 GBq		
Model Number:	NA						
Serial Number:	NA						
References:							
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:			
TN05040	10/25/2005		DCH	AGREEMENT STATE EVENT REPOR	रा		

Narrative:

The licensee reported that a patient scheduled for a renal ultrasound was administered 925 MBq (25 mCi) of Tc-99m MDP for a bone scan. The technician approached the patient, stated a name, and asked the patient if that was his name. The patient responded affirmatively and was injected with the radiopharmaceutical. It was later learned that the intended recipient of the dose was a woman. With the permission of his primary care physician, the administered patient received the bone scan. This event was caused by the technician's assumption that the intended patient was a man and the failure to follow patient identification procedures. To prevent recurrence, the licensee retrained applicable personnel on patient identification procedures.

applicable personnel on pa				
Event Da	ate: 07/08/2005	Discovery Date: 07/08/2005	Report Date:	07/08/2005
Licensee/Reporting Party In Agreement State Regulated License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:		Reciprocity: NONE Name: PORTER MEDIC City: MIDDLEBURY State: VT Zip Code: 0575	CAL CENTER, INC. 3	
Site of Event: Site Name: MIDDLEBURY State: VT				
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	Name: NA City: NA State: NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:		Abnormal Occurrence: Investigation: NMED Record Complete: Event Closed by Region/Stat	N N Y e: N	
Old Cause: PROCEDURE Corrective Actions Informat Action Number: Corrective MD2	NOT FOLLOWED	R WRONG PROCEDURE USED		
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed: 07/	08/2005		
Given: Diagnostic Study: BO	NE SCAN			
Radiopharmaceutical: MD Radionuclide: TC-99M	P/MEDRONATE/OSTEOL Activity:	ITE 25 mCi 925 MBq		
Intended: A therapeutic procedure/dia	agnostic study was not inter	nded.		

% Dose Exceeds Prescribed:NA% Dose is Less Than Prescribed:NAEffect on Patient:

Source of Radiation:						
MD2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rad	dionuclide or Voltage (kVp/l	MeV): TC-99M	
Manufacturer:	NR		Acti	ivity:	0.025 Ci	0.925 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
LTR050921	10/04/2005		RLS	NRC LETTER		
ML052160342	10/04/2005		RLS	LICENSEE REPORT		
ML052160342	10/04/2005		RLS	REGION REPORT		

Narrative:

The licensee reported that a patient scheduled for a routine stress test without the use of radioactive material was administered 0.93 GBq (25 mCi) of Tc-99m myoview. The technologist misread the order thinking the physician ordered a stress cardiac perfusion scan. The technologist was retrained on the correct method of interpreting orders to prevent future occurrences. The physician and patient were notified.

notified.					
Event Dat	te: 08/16/2005	Discovery Date:	08/16/2005	Report Date:	08/16/2005
Licensee/Reporting Party Info Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:		Reciprocity: Name: City: State: TN	NONE SAINT MARY'S M KNOXVILLE Zip Code: 37917	EDICAL CENTER,	INC.
Site of Event: Site Name: KNOXVILLE State: TN					
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:	N Event: Y Y N			N N Y Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION T Old Cause: INATTENTION T Old Cause: INATTENTION T Corrective Actions Information Action Number: Corrective MD2 1 PERSONN	TO DETAIL on:	NAL TRAINING			
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed: 08/0	04/2005			
Given: Diagnostic Study: CAR	RDIAC PERFUSION				
Radiopharmaceutical: MYC Radionuclide: TC-99M	OVIEW Activity:	25 mCi	925 MBq		
Intended: A therapeutic procedure/diag	gnostic study was not inten	ded.			

Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rad	ionuclide or Voltage (kVp/	MeV): TC-99M	
Manufacturer:	NR		Acti	vity:	0.025 Ci	0.925 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
TN05093	10/03/2005		DCH	AGREEMENT STATE E	EVENT REPORT	
TN05093A	10/26/2005		DCH	AGREEMENT STATE E	EVENT REPORT	

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Last Updated: 10/26/2005

Narrative:

The licensee reported that a patient prescribed to receive 0.3 GBq (8 mCi) of Tc-99m pertechnitate was administered 0.26 GBq (7 mCi) of Tc-99m MAA. The physicians were notified of the event. All staff was counseled regarding the incident and proper measures have been reviewed by the individuals to ensure that the radiopharmaceutical labels are properly read by the staff and that they are certain of the procedure prior to administration. The correct diagnostic study was completed.

procedure prior to administr	ration. The correct diagnostic	c study was com	pleted.		
Event Da	te: 05/29/2005 E	Discovery Date:	05/29/2005	Report Date:	05/29/2005
Licensee/Reporting Party Inf	formation:				
Agreement State Regulated:	: YS	Reciprocity:	NONE		
License Number:	TN-R-79009	Name:	METHODIST HEA	LTHCARE UNIVE	RSITY HOSPITAL
NRC Docket Number:	NA	City:	MEMPHIS		
NRC Program Code:	NA	State: TN	Zip Code: 38104		
Responsible NRC Region:	1				
Site of Event:					
Site Name: MEMPHIS					
State: TN					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	-	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal C	ccurrence.	N	
Agreement State Reportable		Investigatio		N	
Atomic Energy Act Material:		0	ord Complete:	Y	
Consultant Hired:	Ň		ed by Region/State:		
Corrective Actions Informati Action Number: Corrective MD2	ACEUTICAL OR DOSE ORD ion:		STOOD		
Patient Information:					
Patient Number: 1					
Patient Informed: N	Date Informed:				
Given: Diagnostic Study: LUN	NG PERFUSION				
Radiopharmaceutical: MA/ Radionuclide: TC-99M	A (MACROAGGREGATED A Activity:	ALBUMIN) 7 mCi	259 MBq		
Intended:					
Diagnostic Study: GAS	STROINTESTINAL SYSTEM	I			
Radiopharmaceutical: SPE	ERT/PERT (PERTECHNETA	TE-TCO4			
% Dose Exceeds Prescribed	d: NA				
% Dose is Less Than Presc					
Effect on Patient:					
Source of Radiation:					

Source Number:	1								
Source/Radioactive N	laterial:	UNSEALED SOUR	CE RADIO	PHARM	Radior	uclide or Volta	age (kVp/Me	eV): TC-99M	
Manufacturer:		NR			Activity	<u>/:</u>		0.007 Ci	0.259 GBq
Model Number:		NA							
Serial Number:		NA							
Device/Associated Equ	uipment:	:							
MD2									
Device Number: 1									
Device Name: S	YRINGE				Model	Number:	NA		
Manufacturer: N	R				Serial I	Number:	NA		
References:									
Reference Number:	Entry	y Date: Retract	on Date:	Coder Initi	ials: F	Reference Ty	pe:		
TN05065	10/03	3/2005		DCH	1	AGREEMENT	STATE EV	ENT REPORT	
TN05065A	10/26	6/2005		DCH	1	AGREEMENT	STATE EV	ENT REPORT	

Narrative:

The licensee reported distr buting three improperly tagged doses of Tc-99m myoview, each containing an activity of 1.11 GBq (30 mCi), to Knoxville Cardiovascular. The doses were administered to three patients and upon interpreting the results of the scans, it was determined that the distribution within the body was not to the intended target organs. The remainder of the doses delivered to Knoxville Cardiovascular were returned to the licensee. The licensee determined that the tagging was not proper and was only in the range of 10%. The QA of the batch documented a 95% tag. The root cause was a compounding error made by the pharmacist. The licensee is now including a thorough vial inspection and permanent labeling of compounding kits. The QC procedure for myoview kits has been reevaluated. All licensee personnel have been notified of the new procedures.

Event Da	te: 04/29/2005	Discovery Date:	05/06/2005	Report Date:	05/06/2005
Licensee/Reporting Party In	formation:				
Agreement State Regulated:	YS	Reciprocity:	NONE		
License Number:	TN-R-47080	Name:	CARDINAL HEALT	Ή	
NRC Docket Number:	NA	City:	KNOXVILLE		
NRC Program Code:	NA	State: TN	Zip Code: 37921		
Responsible NRC Region:	1				
Site of Event:					
Site Name: KNOXVILLE					
State: TN					
Additional Involved Party:					
License Number:	NR	Name:	KNOXVILLE CARE	DIOVASCULAR	
NRC Docket Number:	NR	City:	KNOXVILLE		
NRC Program Code:	NR	State: TN	Zip Code: NR		
Responsible NRC Region:	1				
Other Information:					
NRC Reportable Event:	Ν	Abnormal O	ccurrence:	Ν	
Agreement State Reportable	e Event: Y	Investigation	ו:	Ν	
Atomic Energy Act Material:	Y	NMED Reco	ord Complete:	Y	
Consultant Hired:	Ν	Event Close	d by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROR Old Cause: WRONG REAGENT KIT RECONSTITUTED Corrective Actions Information: Action Number: Corrective Action: MD2 1 NEW QUALITY MANAGEMENT PLAN

- 2 PROCEDURE MODIFIED
- 3 PERSONNEL RECEIVED ADDITIONAL TRAINING

Patient Information:

Patient Number: 1	-	to before 1			
Patient Informed: U	Da	te Informed:			
Given:					
Diagnostic Study:	NR				
Radiopharmaceutical:	NR				
Radionuclide: TC-99	M	Activity:	30 mCi	1110 MBq	
Intended:					
Diagnostic Study:	CARDIAC SO	CAN			
Radiopharmaceutical:	MYOVIEW				
% Dose Exceeds Pres		NA			
% Dose is Less Than I Effect on Patient:	Prescribed:	NA			
Patient Number: 2					
Patient Informed: U	Da	te Informed:			
Given:					
Diagnostic Study:	NR				
Radiopharmaceutical:	NR				
Radionuclide: TC-99	M	Activity:	30 mCi	1110 MBq	
Intended:					
Diagnostic Study:	CARDIAC SO	CAN			
Radiopharmaceutical:	MYOVIEW				
% Dose Exceeds Pres	cribed:	NA			
% Dose is Less Than I	Prescribed: 1	NA			
Effect on Patient:					
Patient Number: 3					
Patient Informed: U	Da	te Informed:			
Given:					
Diagnostic Study:	NR				
Radiopharmaceutical:	NP				
Radionuclide: TC-99		Activity:	30 mCi	1110 MBq	
Intended:					
Diagnostic Study:	CARDIAC SO	CAN			
Radiopharmaceutical:	MYOVIEW				
% Dose Exceeds Pres	cribed:	NA			
% Dose is Less Than I		NA			
Effect on Patient:					
ource of Radiation:					

Source Number: 1					
Source/Radioactive Material:	UNSEALED SOURCE RADIOPH	HARM Rad	lionuclide or Voltage (kVp/MeV	/): TC-99M	
Manufacturer:	NR	Activ	vity:	0.03 Ci	1.11 GBq
Model Number:	NA				
Serial Number:	NA				
Source Number: 2					
Source/Radioactive Material:	UNSEALED SOURCE RADIOPH	HARM Rad	lionuclide or Voltage (kVp/MeV	/): TC-99M	
Manufacturer:	NR	Activ	vity:	0.03 Ci	1.11 GBq
Model Number:	NA				
Serial Number:	NA				
Source Number: 3					
Source/Radioactive Material:	UNSEALED SOURCE RADIOPH	HARM Rad	lionuclide or Voltage (kVp/MeV	/): TC-99M	
Manufacturer:	NR	Activ	vity:	0.03 Ci	1.11 GBq
Model Number:	NA				
Serial Number:	NA				
References:					
Reference Number: Entr	ry Date: Retraction Date:	Coder Initials:	Reference Type:		
TN05055 09/2	8/2005	DCH	AGREEMENT STATE EVEN	NT REPORT	

Narrative:

The University of Alabama reported that a patient received 0.51 GBq (13.9 mCi) of Tc-99m Choletec instead of the intended 0.51 GBq (13.9 mCi) of Tc-99m Cardiolite. One hour after injection, no heart image showed up on the patient scan, only a liver image. The licensee was contacted and advised of the incident. The licensee's investigation concluded that a mistake was made by the pharmacist and the wrong radiopharmaceutical was dispensed (a Choletec dose was labeled as Cardiolite). Corrective actions taken by the licensee included modifying procedures.

modifying procedures.					
Event Date	: 08/02/2005	Discovery Date:	08/02/2005	Report Date:	08/02/2005
Licensee/Reporting Party Info Agreement State Regulated: `		Reciprocity:	NONE		
License Number: NRC Docket Number: NRC Program Code: I	AL-1399 NA NA 1	Name: City:		JCLEAR PHARMAC	CY .
Site of Event: Site Name: BIRMINGHAM State: AL					
Additional Involved Party:					
NRC Docket Number:	AL-0266 NA NA 1	City:	UNIVERSITY OF BIRMINGHAM Zip Code: 35294		
Other Information:					
NRC Reportable Event: Agreement State Reportable E	N Event: Y	Abnormal Oc Investigation	:	N Y	
Atomic Energy Act Material: Consultant Hired:	Y N	NMED Reco Event Closed	rd Complete: d by Region/State	Y : Y	
	n:				
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed:				
Given: Diagnostic Study: HEPA	ATOBILIARY				
Radiopharmaceutical: MEBF Radionuclide: TC-99M	ROFENIN/CHOLETECH Activity:	13.9 mCi	514.3 MBq		
Intended: Diagnostic Study: CARI	DIAC PERFUSION				
Radiopharmaceutical: SEST	AMIBI/CARDIOLITE				
% Dose Exceeds Prescribed: % Dose is Less Than Prescrib Effect on Patient:	NA bed: NA				

Source of Radiation:

MD2								
Source Number:	1							
Source/Radioactive	e Material:	UNSEALED	SOURCE RADIC	PHARM	Radionucli	de or Voltage (k	(Vp/MeV): TC-99M	
Manufacturer:		NR			Activity:		0.0139 Ci	0.5143 GBq
Model Number:		NA						
Serial Number:		NA						
Device/Associated	Equipmen	t:						
MD2								
Device Number:	1							
Device Name:	SYRING	Ξ			Model Nun	nber:	NA	
Manufacturer:	NR				Serial Num	iber:	NA	
References:								
Reference Numbe	er: Enti	ry Date: R	Retraction Date:	Coder Initia	ls: Refe	rence Type:		
AL050043	09/0	6/2005		DCH	AGR	EEMENT STAT	TE EVENT REPORT	

Narrative:

The licensee reported that a patient received 223.9 MBq (6.05 mCi) of I-131 for a thyroid scan instead of the intended I-123 scan. The doctor wrote the prescription for I-131, when he meant it to be I-123. The event occurred on 8/9/2005 and was discovered on 8/11/2005. The doctor and patient have been notified.

The doctor and patient		
Even	t Date: 08/09/2005	Discovery Date: 08/11/2005 Report Date: 08/16/2005
Licensee/Reporting Part	ty Information:	
Agreement State Regula	ated: YS	Reciprocity: NONE
License Number:	FL-1203-1	Name: FLAGLER HOSPITAL, INC.
NRC Docket Number:	NA	City: SAINT AUGUSTINE
NRC Program Code:	NA	State: FL Zip Code: NR
Responsible NRC Regio	on: 1	
Site of Event: Site Name: SAINT AUC State: FL	GUSTINE	
Additional Involved Part	v:	
License Number:	NA	Name: NA
NRC Docket Number:	NA	City: NA
NRC Program Code:	NA	State: NA Zip Code: NA
Responsible NRC Regio		
Other Information:		
NRC Reportable Event:	Ν	Abnormal Occurrence: N
Agreement State Report		Investigation: Y
Atomic Energy Act Mate		NMED Record Complete: Y
Consultant Hired:	N	Event Closed by Region/State: Y
Corrective Actions Inform Action Number: Corre MD2	IAGNOSTIC STUDY OR TH mation:	ERAPY REQUESTED
Detient Information.		
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed:	
Given: Diagnostic Study:	THYROID UPTAKE MEASI	JREMENT
Dediankarraantiaal		
Radiopharmaceutical: Radionuclide: I-131	Activity:	6.05 mCi 223.85 MBq
Intended:		
Diagnostic Study:	THYROID IMAGING	
Radiopharmaceutical:	SODIUM IODIDE	
% Dose Exceeds Presc	ribed: NA	

% Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation:

Source Number: 1						
Source/Radioactive Materi	ial: UNSEAL	ED SOURCE RADIO	PHARM Rac	lionuclide or Voltage (kV	p/MeV): I-131	
Manufacturer:	NR		Acti	vity:	0.00605 Ci	0.22385 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number: E	Intry Date:	Retraction Date:	Coder Initials:	Reference Type:		
EN41920 0	8/22/2005		DCH	EVENT NOTIFICATIO		ROM AN
				AGREEMENT STATE	-	_
FL05-113 0	9/13/2005		DCH	AGREEMENT STATE	EVENT REPORT	Г
LTR050919 0	9/19/2005		RLS	NRC LETTER		

Narrative:

The licensee reported that a 61-year-old female patient was administered 1.55 MBq (42 uCi) of I-131 (NaI) without a written directive prepared or signed by the authorized user. The event was discovered during a routine audit of Nuclear Medicine records. The purpose of the administration was to ascertain the thyroid uptake fraction and image the thyroid tissue. The prescribed dose range, as set by the authorized user, was 0.3 to 0.67 MBq (8 to 18 uCi). The administered dose was 133% higher than the maximum dose allowed by the authorized user for this diagnostic procedure. Using NUREG CR-6435, the licensee estimated the patient's dose as 17.6 cGy (rad) to the thyroid and 1.64 cSv (rem) to the whole body. The licensee determined that the proper amount of I-131 had been ordered, but the radiopharmacy sent more than was ordered. Also, the nuclear medicine technologist failed to verify the dose against the requested study. Based on the licensee's dose estimates, the NRC believes that this event does not meet reportable requirements. An inspection of the licensee's program is planned for January 2006. Corrective actions taken by the licensee included procedure changes and conducting a training session regarding the requirements for written directives and changes in procedure.

Event Dat	t e: 0	7/14/2005	Discovery Date	: 07/20/2005	Report Date:	07/21/2005			
Licensee/Reporting Party Inf	Licensee/Reporting Party Information:								
Agreement State Regulated:	NO		Reciprocity	: NONE					
License Number:	45-19	057-01	Name:	MONTGOMERY R	EGIONAL HOSPIT	AL			
NRC Docket Number:	03015	297	City:	BLACKSBURG					
NRC Program Code:	02120		State: VA	Zip Code: 24060					
Responsible NRC Region:	1								
Site of Event: Site Name: BLACKSBURG State: VA									
Additional Involved Party: License Number:	NA		Name:	NA					
NRC Docket Number:	NA		City:	NA					
NRC Program Code:	NA			Zip Code: NA					
Responsible NRC Region:	NA								
Other Information:									
NRC Reportable Event:		Ν	Abnormal C	Occurrence:	Ν				
Agreement State Reportable	Event:	Ν	Investigatio	n:	Ν				
Atomic Energy Act Material:		Y	NMED Rec	ord Complete:	Y				
Consultant Hired:		Ν	Event Close	ed by Region/State:	Y				

Event Type:

MD2 - MEDICAL EVENT

Event Cause:

MD2

Cause: FAILURE TO FOLLOW PROCEDURE OR WRONG PROCEDURE USED

Old Cause: PROCEDURE NOT FOLLOWED

Corrective Actions Information:

Action Number: Corrective Action:

MD2

1 PROCEDURE MODIFIED

2 PERSONNEL RECEIVED ADDITIONAL TRAINING

Patient Information:

Patient Number: 1						
Patient Informed: U	Date Info	ormed:				
Given:						
Diagnostic Study:	THYROID UPTAKE	E MEASUREMEN	NT			
Radiopharmaceutical:	SODIUM IODIDE					
Radionuclide: I-131	Ac	ctivity: 0.0	042 mCi	1.554 MBq		
Intended:						
Diagnostic Study:	THYROID UPTAKE	E MEASUREMEN	NT			
Radiopharmaceutical:	SODIUM IODIDE					
% Dose Exceeds Pres	cribed: 133					
% Dose is Less Than F						
Effect on Patient:						
ource of Radiation:						
1D2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEALED	SOURCE RADIO	OPHARM R	adionuclide or Volt	age (kVp/MeV): I-131	
Manufacturer:	NR		A	ctivity:	0.000042 Ci	0.001554 GBq
Model Number:	NA					
Serial Number:	NA					
leferences:						
Reference Number:	Entry Date: R	etraction Date:	Coder Initials	: Reference Ty	pe:	
EN41860	07/25/2005		DCH	EVENT NOTIF	FICATION	
LTR051103	11/07/2005		DCH	NRC LETTER		

Narrative:

The licensee reported that a 25-year-old female patient was administered 1.15 MBq (31 uCi) of I-131 (NaI) without a written directive prepared or signed by the authorized user. The event was discovered during a routine audit of Nuclear Medicine records. The purpose of the administration was to ascertain the thyroid uptake fraction and image the thyroid tissue. The prescribed dose range, as set by the authorized user, was 0.3 to 0.67 MBq (8 to 18 uCi). The administered dose was 72% higher than the maximum dose allowed by the authorized user for this diagnostic procedure. Using NUREG CR-6435, the licensee estimated the patient's dose as 40.3 cGy (rad) to the thyroid and 1.21 cSv (rem) to the whole body. The licensee determined that the proper amount of I-131 had been ordered, but the radiopharmacy sent more than was ordered. Also, the nuclear medicine technologist failed to verify the dose against the requested study. Based on the licensee's dose estimates, the NRC believes that this event does not meet reporting requirements. An inspection of the licensee's program is planned for January 2006. Corrective actions taken by the licensee included procedure changes and conducting a training session regarding the requirements for written directives and changes in procedure.

Event Dat	t e: 0	7/18/2005	Discovery	Date:	07/20/2005	Report Date:	07/21/2005
Licensee/Reporting Party Inf	ormati	on:					
Agreement State Regulated:	NO		Recip	orocity:	NONE		
License Number:	45-190	057-01	Name	e:	MONTGOMERY R	EGIONAL HOSPIT	AL
NRC Docket Number:	03015	297	City:		BLACKSBURG		
NRC Program Code:	02120		State	: VA	Zip Code: 24060		
Responsible NRC Region:	1						
Site of Event: Site Name: BLACKSBURG State: VA							
Additional Involved Party: License Number:	NA		Name	. .	NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State	: NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abno	rmal O	occurrence:	Ν	
Agreement State Reportable	Event:	Ν	Inves	tigatio	n:	Ν	
Atomic Energy Act Material:		Y	NME	D Reco	ord Complete:	Y	
Consultant Hired:		Ν	Even	t Close	ed by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT

Event Cause: MD2

Cause: FAILURE TO FOLLOW PROCEDURE OR WRONG PROCEDURE USED

Old Cause: PROCEDURE NOT FOLLOWED

Corrective Actions Information:

Action Number: Corrective Action:

MD2

1 PROCEDURE MODIFIED

2 PERSONNEL RECEIVED ADDITIONAL TRAINING

Patient Information:

Patient Number: 1						
Patient Informed: U	Date	Informed:				
Given:						
Diagnostic Study:	THYROID UPT	AKE MEASUREMEN	IT			
Radiopharmaceutical:	SODIUM IODID	E				
Radionuclide: I-131		Activity: 0.0	31 mCi	1.147 MBq		
Intended:						
Diagnostic Study:	THYROID UPT	AKE MEASUREMEN	IT			
Radiopharmaceutical:	SODIUM IODID	E				
% Dose Exceeds Pres	cribed: 72					
% Dose is Less Than F	Prescribed: NA					
Effect on Patient:						
Source of Radiation:						
/ID2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIC	PHARM Ra	adionuclide or Voltage (I	«Vp/MeV): I-131	
Manufacturer:	NR		Ac	tivity:	0.000031 Ci	0.001147 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
EN41860	07/25/2005		DCH	EVENT NOTIFICAT	ION	
LTR051103	11/07/2005		DCH	NRC LETTER		
LTR051109	11/10/2005		DCH	NRC LETTER		

Narrative:

The licensee reported that a patient was administered 0.74 GBq (20 mCi) of Tc-99m MDP for a bone scan instead of the prescribed dose of 0.3 GBq (8 mCi) of Tc-99m MAA for a lung perfusion test. The technologist selected the wrong syringe. Corrective actions taken by the licensee included reinstructing personnel.

licensee included reinstructing personnel.		
Event Date: 06/09/2005	Discovery Date: 06/09/2005 Report Date: 06/13/2005	
Licensee/Reporting Party Information:	Pacingoity, NONE	
Agreement State Regulated: YS		
License Number: CA-0389-37	Name: RADIOLOGY MEDICAL GROUP	
NRC Docket Number: NA	City: SAN DIEGO	
NRC Program Code: NA	State: CA Zip Code: 92103	
Responsible NRC Region: 4		
Site of Event:		
Site Name: SAN DIEGO		
State: CA		
Additional Involved Party:		
License Number: NA	Name: NA	
NRC Docket Number: NA	City: NA	
NRC Program Code: NA	State: NA Zip Code: NA	
Responsible NRC Region: NA		
Other Information:		
NRC Reportable Event: N	Abnormal Occurrence: N	
Agreement State Reportable Event: Y	Investigation: Y	
Atomic Energy Act Material: Y	NMED Record Complete: Y	
Consultant Hired: N	Event Closed by Region/State: Y	
Event Cause: MD2 Cause: INATTENTION TO DETAIL Old Cause: WRONG SYRINGE SELECTED FROM Corrective Actions Information: Action Number: Corrective Action: MD2 1 PERSONNEL RECEIVED ADDIT		
Patient Information:		
Patient Number: 1		
Patient Informed: U Date Informed:		
Given:		
Diagnostic Study: BONE SCAN		
Diagnostic Olday. DOINE COAN		
Radiopharmaceutical: MDP/MEDRONATE/OSTE	OLITE	
Radionuclide: TC-99M Activity:	20 mCi 740 MBg	
Intended:		
Diagnostic Study: LUNG PERFUSION		
Radiopharmaceutical: MAA (MACROAGGREGAT	ED ALBUMIN)	
% Dose Exceeds Prescribed: NA		
% Dose is Less Than Prescribed: NA		
Effect on Patient:		

Source of Radiation:

Source Number: 1					
Source/Radioactive Material:	UNSEALED SOURCE RADIOF	PHARM Radion	uclide or Voltage (kVp/Me	eV): TC-99M	
Manufacturer:	NR	Activity	:	0.02 Ci	0.74 GBq
Model Number:	NA				
Serial Number:	NA				
Device/Associated Equipmen	t:				
MD2					
Device Number: 1					
Device Name: SYRING	E	Model	Number: NA		
Manufacturer: NR		Serial N	Number: NA		
References:					
Reference Number: Entr	ry Date: Retraction Date:	Coder Initials: F	Reference Type:		
CA-XCA754 07/1	19/2005	DCH A	GREEMENT STATE EV	ENT REPORT	
LTR050816 08/1	17/2005	DCH A	GREEMENT STATE LE	ITER	

Last Updated: 08/11/2005

Narrative:

The licensee dispensed four Tc-99m diagnostic radiopharmaceutical doses that were mislabeled. All four doses were labeled as bone scan agents, but actually contained gal bladder imaging agents. Huntsville Hospital ordered three doses and Marshall Medical Center North ordered the fourth. All four doses were administered before the error was discovered. The licensee investigated incident and determined the cause was pharmacy error. A pharmacist mistakenly pulled a choletec vial off the shelf and placed it into an MDP tungsten container, then proceeded to compound the customers' requests. Corrective actions taken by the licensee included modifying procedures.

proceeded to compound the c			-		
		iscovery Date:	05/13/2005	Report Date:	05/13/2005
NRC Docket Number: N NRC Program Code: N Responsible NRC Region: 1 Site of Event: 1 Site Name: HUNTSVILLE State: AL Additional Involved Party: License Number: N NRC Docket Number: N	mation: ′S \L-1068 IA IA	Name: City:	NONE CARDINAL HEAL HUNTSVILLE Zip Code: NR HUNTSVILLE HC HUNTSVILLE		05/13/2005
NRC Program Code: N Responsible NRC Region: 1		State: AL	Zip Code: NR		
Other Information: NRC Reportable Event: Agreement State Reportable E Atomic Energy Act Material: Consultant Hired:	N vent: Y Y N			N N Y : Y	
MD2 Cause: HUMAN ERROR Old Cause: WRONG VIAL SE Corrective Actions Information Action Number: Corrective A MD2 1 PROCEDUR	1:	6 DOSE			
Patient Information: Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: GALLI	BLADDER				
Radiopharmaceutical: MEBR Radionuclide: TC-99M	OFENIN/CHOLETECH Activity:	NR mCi	NR MBq		
Intended: Diagnostic Study: BONE	SCAN				
Radiopharmaceutical: MDP/I	MEDRONATE/OSTEOLITE				
% Dose Exceeds Prescribed: % Dose is Less Than Prescrib Effect on Patient:	NA ed: NA				

Patient Number: 2 Patient Informed: U	Date Informed:		
Given: Diagnostic Study:	GALLBLADDER		
Radiopharmaceutical: Radionuclide: TC-99	MEBROFENIN/CHOLETECH Activity:	NR mCi	NR MBq
Intended: Diagnostic Study:	BONE SCAN		
Radiopharmaceutical:	MDP/MEDRONATE/OSTEOLITE		
% Dose Exceeds Preso % Dose is Less Than P Effect on Patient: Patient Number: 3	rescribed: NA		
Patient Informed: U Given:	Date Informed:		
Diagnostic Study:	GALLBLADDER		
Radiopharmaceutical: Radionuclide: TC-991	MEBROFENIN/CHOLETECH M Activity:	NR mCi	NR MBq
Intended: Diagnostic Study:	BONE SCAN		
Radiopharmaceutical:	MDP/MEDRONATE/OSTEOLITE		
% Dose Exceeds Preso % Dose is Less Than P Effect on Patient: Patient Number: 4	rescribed: NA		
Patient Informed: U Given:	Date Informed:		
Diagnostic Study:	GALLBLADDER		
Radiopharmaceutical: Radionuclide: TC-991	MEBROFENIN/CHOLETECH M Activity:	NR mCi	NR MBq
Intended: Diagnostic Study:	BONE SCAN		
Radiopharmaceutical:	MDP/MEDRONATE/OSTEOLITE		
% Dose Exceeds Preso % Dose is Less Than P Effect on Patient: Source of Radiation: MD2			

Source Number:	1								
		UNSEALED SOURCE RADIO			ide or Voltage (kVp/				
Manufacturer:		NR	A	Activity:		NF	R Ci	NR	0
Model Number:		NA							
Serial Number:		NA							
Source Number:	2								
Source/Radioactive M	Material:	UNSEALED SOURCE RADIO)PHARM F	Radionuc	ide or Voltage (kVp/	'MeV):	TC-99M		
Manufacturer:		NR	A	Activity:		NF	R Ci	NR	(
Model Number:		NA							
Serial Number:		NA							
Source Number:	3								
Source/Radioactive M	Aaterial:	UNSEALED SOURCE RADIO	OPHARM F	Radionuc	ide or Voltage (kVp/	'MeV):	TC-99M		
Manufacturer:		NR	A	Activity:		NF	R Ci	NR	0
Model Number:		NA		-					
Serial Number:		NA							
Source Number:	4								
Source/Radioactive	Aaterial:	UNSEALED SOURCE RADIO	OPHARM F	Radionuc	ide or Voltage (kVp/	/MeV):	TC-99M		
Manufacturer:		NR		Activity:		,	RCi	NR	(
Model Number:		NA							
Serial Number:		NA							
ID2 Device Number: 1	I								
Device Name: S	SYRINGE		Ν	Model Nu	mber: NA				
Manufacturer:	١R		S	Serial Nur	nber: NA				
Device Number: 2	2								
Device Name: S	SYRINGE		Ν	Model Nu	mber: NA				
Manufacturer: N	١R		S	Serial Nur	mber: NA				
Device Number: 3	3								
	SYRINGE		Ν	Model Nu	mber: NA				
Device Name: S	٧R		S	Serial Nur	nber: NA				
Manufacturer: N Device Number: 4			Ν	Model Nu	mber: NA				
Manufacturer: N Device Number: 4 Device Name: 5	ı			Model Nu Serial Nur					
Manufacturer: M Device Number: 4 Device Name: 5 Manufacturer: N	I SYRINGE								
Manufacturer: N Device Number: 4 Device Name: 5	I Syringe Nr	v Date: Retraction Date:	S	Serial Nur					
Manufacturer: N Device Number: 4 Device Name: 5 Manufacturer: N Deferences:	I SYRINGE NR Entry		S	Serial Nur s: Ref	nber: NA	EVENT	REPORT		

Narrative:

The licensee reported that a patient was administered 0.67 GBq (18.1 mCi) of Tc-99m HDP for a bone scan instead of the prescribed 0.13 GBq (3.5 mCi) of TI-201 for a cardiac scan. The imaging technologist selected the wrong syringe. Corrective action taken by the licensee included reinstructing personnel.

included reinstructing personne	el.	gg			
Event Date:	05/17/2005	Discovery Date:	05/17/2005	Report Date:	05/26/2005
Licensee/Reporting Party Inform	mation:				
Agreement State Regulated: YS	S	Reciprocity:	NONE		
License Number: CA	A-1394-01	Name:	SAINT ROSE HOS	SPITAL	
NRC Docket Number: NA	A	City:	HAYWARD		
NRC Program Code: NA	A	State: CA	Zip Code: 94545		
Responsible NRC Region: 4					
Site of Event:					
Site Name: HAYWARD					
State: CA					
Additional Involved Party:					
License Number: N	Α	Name:	NA		
NRC Docket Number: N		City:	NA		
NRC Program Code: N		-	Zip Code: NA		
Responsible NRC Region: N					
Other Information:					
NRC Reportable Event:	N	Abnormal O	courronco:	N	
Agreement State Reportable Ev		Investigation		Y	
Atomic Energy Act Material:	Y	-	rd Complete:	Y	
Consultant Hired:	N		d by Region/State:		
Cause: INATTENTION TO Old Cause: WRONG SYRINGE Corrective Actions Information: Action Number: Corrective Act MD2	E SELECTED FROM E : ction:				
1 PERSONNE	L RECEIVED ADDITIO	JNAL TRAINING			
Patient Information:					
Patient Number: 1					
Patient Informed: U	Date Informed:				
Given:					
Diagnostic Study: BONE	SCAN				
Radiopharmaceutical: HYDR0	OXYMETHYLENE DIP	HOSPHONATE			
Radionuclide: TC-99M	Activity:	18.1 mCi	669.7 MBq		
Intended:					
Diagnostic Study: CARDI	AC SCAN				
Radiopharmaceutical: NR					
% Dose Exceeds Prescribed: % Dose is Less Than Prescribe	NA ed: NA				

% Dose is Less Than Prescribed: NA Effect on Patient:

Source of Radiation:

Source Number:	1							
Source/Radioactive M	laterial:	UNSEALE	D SOURCE RADIO	PHARM	Radion	uclide or Volta	ige (kVp/MeV): TC-99M	
Manufacturer:		NR			Activity	:	0.0181 Ci	0.6697 GBq
Model Number:		NA						
Serial Number:		NA						
Device/Associated Eq	uipment	::						
MD2								
Device Number: 1								
Device Name: S	SYRINGE	Ξ			Model I	Number:	NA	
Manufacturer: N	IR				Serial N	lumber:	NA	
References:								
Reference Number:	Entr	y Date:	Retraction Date:	Coder Initi	als: R	Reference Typ	e:	
CA-XCA749	06/2	1/2005		DCH	A	GREEMENT	STATE EVENT REPORT	
LTR060526	05/3	0/2006		DCH	A	GREEMENT	STATE LETTER	

Narrative:

The licensee reported administering a dose of Tc-99m mebrofenin instead of the prescribed dose of Tc-99m MAA. The licensee determined that the pharmacist and technician had drawn the patient dose from the wrong product vial.

Event Date	e: 05/09/	2005 Dis	covery Date	: 05/09/2005	Report Date:	05/17/2005
Licensee/Reporting Party Info	ormation:					
Agreement State Regulated:	YS		Reciprocity	: NONE		
License Number:	CA-2541-1	9	Name:	TARZANA REGIO	NAL MEDICAL CEI	NTER
NRC Docket Number:	NA		City:	TARZANA		
	NA		State: CA	Zip Code: 91356		
Responsible NRC Region:	4					
Site of Event:						
Site Name: TARZANA						
State: CA						
Additional Involved Party:						
License Number:	NA		Name:	NA		
NRC Docket Number:	NA		City:	NA		
NRC Program Code:	NA		State: NA	Zip Code: NA		
Responsible NRC Region:	NA					
Other Information:						
NRC Reportable Event:	Ν		Abnormal (Occurrence:	Ν	
Agreement State Reportable	Event: Y		Investigatio	on:	Y	
Atomic Energy Act Material:	Y		NMED Red	cord Complete:	Y	
Consultant Hired:	Ν		Event Clos	ed by Region/State:	Y	
Event Type:						
MD2 - MEDICAL EVENT						
Event Cause:						

NR MBq

MD2

Cause: INATTENTION TO DETAIL

Old Cause: WRONG VIAL SELECTED WHEN DRAWING DOSE

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Information:

Patient Number: 1 Patient Informed: U Date Informed:

Given:

Diagnostic Study: NR

Radiopharmaceutical: MEBROFENIN/CHOLETECH Radionuclide: TC-99M Activity: NR mCi

Intended:

Diagnostic Study: NR

Radiopharmaceutical: MAA (MACROAGGREGATED ALBUMIN)

Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rad	lionuclide or Voltage (kVp/l	MeV): TC-99M	
Manufacturer:	NR		Act	vity:	NR Ci	NR GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
CA-XCA748	06/21/2005		DCH	AGREEMENT STATE E	VENT REPORT	
LTR061031	11/06/2006		DCH	AGREEMENT STATE L	ETTER	

Narrative:

The licensee reported that a patient scheduled for 0.925 GBq (25 mCi) of Tc-99m tetrafosin for a cardiac stress test was mistakenly given 0.888 GBq (24 mCi) of Tc-99m MDP for a bone scan. The imaging technologist failed to verify the syringe's contents. Corrective action taken by the licensee included implementing new procedures for handling and labeling radiopharmaceuticals.

Event Da	te: 04/13/2005	Discovery Date: 04/1	3/2005	Report Date:	05/04/2005
Licensee/Reporting Party Int		···· , - ···· · ···			-
Agreement State Regulated:		Reciprocity: NONE			
License Number:	CA-1335-19			UNIVERSITY OF	- CALIFORNIA - LA
NRC Docket Number:	NA		NGELES		
NRC Program Code:	NA	State: CA Zip Co			
Responsible NRC Region:	4				
Site of Event: Site Name: LOS ANGELES State: CA	i				
Additional Involved Party:					
License Number:	NA	Name: NA			
NRC Docket Number:	NA	City: NA			
NRC Program Code:	NA	State: NA Zip Co	de: NA		
Responsible NRC Region:	NA	r			
Other Information:					
NRC Reportable Event:	N	Abnormal Occurren	ice:	N	
Agreement State Reportable		Investigation:		Y	
Atomic Energy Act Material:	Y	NMED Record Corr		Ý	
Consultant Hired:	Ν	Event Closed by Re	•	Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2					
MD2 - MEDICAL EVENT Event Cause:	NGE SELECTED FROM E		-		
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION Old Cause: WRONG SYRIN Corrective Actions Informati Action Number: Corrective MD2 1 NEW PRO	NGE SELECTED FROM E				
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION Old Cause: WRONG SYRIN Corrective Actions Informati Action Number: Corrective MD2	NGE SELECTED FROM E ion: e Action:		-		
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION Old Cause: WRONG SYRIN Corrective Actions Informati Action Number: Corrective MD2 1 NEW PRO Patient Information: Patient Information: Patient Informed: U Given:	NGE SELECTED FROM E ion: e Action: DCEDURE WRITTEN Date Informed:		-		
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION Old Cause: WRONG SYRIN Corrective Actions Informati Action Number: Corrective MD2 1 NEW PRO Patient Information: Patient Information: Patient Informed: U Given:	NGE SELECTED FROM D ion: e Action: DCEDURE WRITTEN		-		
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION Old Cause: WRONG SYRIN Corrective Actions Informati Action Number: Corrective MD2 1 NEW PRO Patient Information: Patient Information: Patient Informed: U Given:	NGE SELECTED FROM E ion: Action: DCEDURE WRITTEN Date Informed: NE SCAN	OOSAGE CART			
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION Old Cause: WRONG SYRIN Corrective Actions Informati Action Number: Corrective MD2 1 NEW PRO Patient Information: Patient Information: Patient Informed: U Given: Diagnostic Study: BOI	NGE SELECTED FROM E ion: Action: DCEDURE WRITTEN Date Informed: NE SCAN	DOSAGE CART	888 MBq		
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION Old Cause: WRONG SYRIN Corrective Actions Informati Action Number: Corrective MD2 1 NEW PRO Patient Information: Patient Information: Patient Informed: U Given: Diagnostic Study: BOI Radiopharmaceutical: MD	NGE SELECTED FROM E ion: Action: DCEDURE WRITTEN Date Informed: NE SCAN P/MEDRONATE/OSTEOI	DOSAGE CART	-		
MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION Old Cause: WRONG SYRIN Corrective Actions Informati Action Number: Corrective MD2 1 NEW PRO Patient Information: Patient Information: Patient Informed: U Given: Diagnostic Study: BOI Radiopharmaceutical: MDI Radiopharmaceutical: MDI Radionuclide: TC-99M Intended:	NGE SELECTED FROM E ion: Action: DCEDURE WRITTEN Date Informed: NE SCAN P/MEDRONATE/OSTEOI	DOSAGE CART	-		

Source Number:	1							
Source/Radioactive	Material:	UNSEALE	D SOURCE RADIO	PHARM	Radionucli	de or Voltage (kVp/M	leV): TC-99M	
Manufacturer:		NR			Activity:		0.025 Ci	0.925 GBq
Model Number:		NA						
Serial Number:		NA						
Device/Associated E	quipment	t:						
MD2								
Device Number:	1							
Device Name:	SYRING	Ξ			Model Nun	nber: NA		
Manufacturer:	NR				Serial Num	nber: NA		
References:								
Reference Number	: Entr	y Date:	Retraction Date:	Coder Initia	als: Refe	erence Type:		
CA-XCA746	06/0	1/2005		DCH	AGR	REEMENT STATE EV	/ENT REPORT	
LTR060203	02/0	6/2006		DCH	AGR	REEMENT STATE LE	TTER	

Narrative:

The licensee reported that a patient scheduled for 0.31 GBq (8.5 mCi) of Xe-133 for a lung ventilation study was mistakenly given 0.15 GBq (4 mCi) of Tc-99m for a lung perfusion study. The ward clerk ordered the wrong study for the patient.

Event Da	te: 0	2/16/2005	Disco	very D	ate:	02/16/2005	Report Date:	05/12/2005
Licensee/Reporting Party Int	formati	ion:						
Agreement State Regulated:	YS		F	Recipro	city:	NONE		
License Number:	CA-07	788-19	Ν	lame:		SAN PEDRO HOSI	PITAL	
NRC Docket Number:	NA		C	City:		SAN PEDRO		
NRC Program Code:	NA		S	State:	CA	Zip Code: 90732		
Responsible NRC Region:	4							
Site of Event:								
Site Name: SAN PEDRO								
State: CA								
Additional Involved Party:								
License Number:	NA		Ν	lame:		NA		
NRC Docket Number:	NA		C	City:		NA		
NRC Program Code:	NA		S	State:	NA	Zip Code: NA		
Responsible NRC Region:	NA							
Other Information:								
NRC Reportable Event:		Ν	A	bnorm	al O	ccurrence:	Ν	
Agreement State Reportable	Event	Y	li	nvestig	atior	1:	Y	
Atomic Energy Act Material:		Y	Ν	IMED I	Reco	ord Complete:	Y	
Consultant Hired:		Ν	E	Event C	lose	d by Region/State:	Y	
Event Type:								
MD2 - MEDICAL EVENT								
Event Cause:								

4 mCi

148 MBq

Event Cause: MD2 Cause: HUMAN ERROR Old Cause: WRONG DIAGNOSTIC STUDY OR THERAPY REQUESTED

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Information:

 Patient Number:
 1

 Patient Informed:
 U

 Date Informed:

Given:

Diagnostic Study: LUNG PERFUSION

Radiopharmaceutical:

Radionuclide: TC-99M Activity:

NR

Intended:

Diagnostic Study: LUNG VENTILATION

Radiopharmaceutical: GAS

Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rad	lionuclide or Voltage (kV	p/MeV): TC-99M	
Manufacturer:	NR		Act	vity:	0.004 Ci	0.148 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
CA-XCA740	05/31/2005		DCH	AGREEMENT STATE	EVENT REPORT	
LTR061031	11/06/2006		DCH	AGREEMENT STATE	LETTER	

Narrative:

The licensee reported that a patient scheduled to receive 370 MBq (10 mCi) of Tc-99m MIBI for a cardiac stress test was administered 9.1 MBq (246 uCi) of I-123 for a thyroid uptake study. The imaging technologist failed to verify the patient's identification. Nuclear medicine staff has been reinstructed on the proper method for patient identification.

has been reinstructed on the p	roper method for patient ide	ntification.	5 · · · · · · · · · · · · · · · · · · ·		
Event Date:	04/21/2005 Dis	covery Date:	04/21/2005	Report Date:	04/26/2005
NRC Docket Number: N/ NRC Program Code: N/	S A-1703-12 A A	Reciprocity: Name: City: State: CA	NONE SAINT JOSEPH H EUREKA Zip Code: 95501	OSPITAL	
Responsible NRC Region: 4 Site of Event: Site Name: EUREKA State: CA					
Additional Involved Party: N/ License Number: N/ NRC Docket Number: N/ NRC Program Code: N/ Responsible NRC Region: N/	A	Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Ev Atomic Energy Act Material: Consultant Hired:	N vent: Y Y N			N Y Y Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION TO Old Cause: WRONG PATIENT Corrective Actions Information: Action Number: Corrective Action MD2 1 PERSONNEL	SELECTED	TRAINING			
Patient Information: Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: THYRC	DID UPTAKE MEASUREME	INT			
Radiopharmaceutical: SODIU Radionuclide: I-123		.246 mCi	9.102 MBq		
Intended: Diagnostic Study: CARDI	AC SCAN				
Radiopharmaceutical: SESTA	MIBI/CARDIOLITE				
% Dose Exceeds Prescribed:	NA				

% Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation:

Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rad	dionuclide or Volta	ige (kVp/MeV): I-123	
Manufacturer:	NR		Act	ivity:	0.000246 Ci	0.009102 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Typ)e:	
CA-XCA737	05/31/2005		DCH	AGREEMENT	STATE EVENT REPOR	Т
CA-XCA737A	06/01/2005		DCH	AGREEMENT	STATE EVENT REPOR	т

Narrative:

The licensee reported that a patient received 0.74 GBq (20 mCi) of Tc-99m sestamibi instead of the prescribed 0.74 GBq (20 mCi) of Tc-99m MDP for a bone scan. The imaging technologist selected the wrong radiopharmaceutical from the hot laboratory. Corrective actions taken by the licensee included reprimanding involved personnel and reinstructing personnel.

taken by the licensee included reprimandi				oratory. Conective actions
Event Date: 04/27/20	Discovery Date:	04/27/2005	Report Date:	04/29/2005
Licensee/Reporting Party Information:				
Agreement State Regulated: YS	Reciprocity:	NONE		
License Number: CA-0107-36	Name:	SAN ANTONIO CO	MMUNITY HOSP	ITAL
NRC Docket Number: NA	City:	UPLAND		
NRC Program Code: NA	State: CA	Zip Code: 91739		
Responsible NRC Region: 4				
Site of Event:				
Site Name: UPLAND				
State: CA				
Additional Involved Party:				
License Number: NA	Name:	NA		
NRC Docket Number: NA	City:	NA		
NRC Program Code: NA		Zip Code: NA		
Responsible NRC Region: NA		P		
Other Information:				
NRC Reportable Event: N	Abnormal C	ccurrence.	N	
Agreement State Reportable Event: Y	Investigatio		Y	
Atomic Energy Act Material: Y	•	ord Complete:	Ŷ	
Consultant Hired: N		ed by Region/State:	Y	
Event Type: MD2 - MEDICAL EVENT				
Event Cause:				
MD2				
Cause: INATTENTION TO DETAIL				
Old Cause: INATTENTION TO DETAIL				
Corrective Actions Information:				
Action Number: Corrective Action:				
MD2				
1 PERSONNEL REPRIM	ANDED			
2 PERSONNEL RECEIVE	ED ADDITIONAL TRAINING			
Defient Information.				
Patient Information: Patient Number: 1				
	formed:			
	ionneu.			
Given:				
Diagnostic Study: CARDIAC SCAN				
Radiopharmaceutical: SESTAMIBI/CAR				
Radionuclide: TC-99M A	ctivity: 20 mCi	740 MBq		
Intended				
Intended:				
Diagnostic Study: BONE SCAN				

Radiopharmaceutical: MDP/MEDRONATE/OSTEOLITE

Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rad	lionuclide or Voltage (kV	p/MeV): TC-99M	
Manufacturer:	NR		Act	vity:	0.02 Ci	0.74 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
CA-XCA735	05/26/2005		DCH	AGREEMENT STATE	EVENT REPORT	
LTR060203	02/06/2006		DCH	AGREEMENT STATE	LETTER	

Narrative:

The licensee reported that a patient received 0.41 GBq (11 mCi) of F-18 FDG for a PET scan instead of the prescribed 0.74 GBq (20 mCi) of Tc-99m MDP for a bone scan. The imaging technologist did not verify the requisition. Corrective actions taken by the licensee included implementing new procedures.

implementing new procedur	es.					
Event Dat	te: 03/29/2005	Discovery Date:	03/29/2005	Report Date:	04/13/2005	
Licensee/Reporting Party Inf	formation:					
Agreement State Regulated:	YS	Reciprocity:	NONE			
License Number:	CA-7109-19	Name:	ANTELOPE VALL	EY OUTPATIENT	MAGING CENTER	
NRC Docket Number:	NA	City:	LANCASTER			
NRC Program Code:	NA	State: CA	Zip Code: 93534			
Responsible NRC Region:	4					
Site of Event:						
Site Name: LANCASTER						
State: CA						
Additional Involved Party:						
License Number:	NA	Name:	NA			
NRC Docket Number:	NA	City:	NA			
NRC Program Code:	NA	State: NA	Zip Code: NA			
Responsible NRC Region:	NA					
Other Information:						
NRC Reportable Event:	Ν	Abnormal C	ccurrence:	Ν		
Agreement State Reportable	Event: Y	Investigation	า:	Y		
Atomic Energy Act Material:	Y		ord Complete:	Y		
Consultant Hired:	Ν	Event Close	d by Region/State:	Y		
Event Type:						
MD2 - MEDICAL EVENT						
Event Cause:						
MD2						
Cause: FAILURE TO FO	OLLOW PROCEDURE O	R WRONG PROCE	DURE USED			
Old Cause: PROCEDURE NOT FOLLOWED						
Corrective Actions Informati						
Action Number: Corrective	Action:					
MD2						
1 NEW PRO	OCEDURE WRITTEN					
Patient Information:						
Patient Number: 1						

11 mCi

407 MBq

Patient Informed: U

Patient Informed: U	Date Informed:
Given: Diagnostic Study:	PET SCAN
Radiopharmaceutical: Radionuclide: F-18	FDG (FLUORODEOXYGLUCOSE) Activity:
Intended: Diagnostic Study:	BONE SCAN
Radiopharmaceutical:	MDP/MEDRONATE/OSTEOLITE
% Dose Exceeds Preso	cribed: NA

% Dose is Less Than Prescribed: NA Effect on Patient: Source of Radiation: MD2

Source Number:	1					
Source/Radioactive Material: UNSE		EALED SOURCE RADIOPHARM Rac		lionuclide or Voltage (kVp/MeV): F-18		
Manufacturer: NR		۲. ۲. ۲. ۲. ۲. ۲. ۲. ۲. ۲. ۲. ۲. ۲. ۲. ۲		vity: 0.011 Ci	0.407 GBq	
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
CA-XCA736	05/26/2005		DCH	AGREEMENT STATE EVENT REPO	DRT	
LTR060807	08/09/2006)9/2006 D0		AGREEMENT STATE LETTER	REEMENT STATE LETTER	

Narrative:

The licensee reported that a patient was administered 0.37 GBq (10 mCi) of Tc-99m MDP for a bone scan instead of the prescribed 0.37 GBq (10 mCi) of Tc-99m pertechnetate for a thyroid scan. It was determined that the radiopharmacy had mislabeled the syringe.

Event Date	: 04/08/2005	Discovery Date	: 04/08/2005	Report Date:	04/28/2005
Licensee/Reporting Party Info	rmation:				
Agreement State Regulated: \	YS	Reciprocity	: NONE		
License Number: 0	CA-0456-38	Name:	CALIFORNIA PAC	IFIC MEDICAL CE	NTER
NRC Docket Number:	NA	City:	SAN FRANCISCO		
NRC Program Code:	NA	State: CA	Zip Code: 94114		
Responsible NRC Region: 4	4				
Site of Event: Site Name: SAN FRANCISCO State: CA	D				
Additional Involved Party:		Nama			
	NR	Name:	NR		
	NR	City:	NR Zie Ostas ND		
	NR	State: NR	Zip Code: NR		
	NR				
Other Information:					
NRC Reportable Event:	N		Occurrence:	Ν	
Agreement State Reportable E	Event: Y	Investigatio		Y	
Atomic Energy Act Material:	Y		ord Complete:	Y	
Consultant Hired:	Ν	Event Close	ed by Region/State:	Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION TO) DETAIL				

Old Cause: SYRINGE MISLABELED

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Information:

 Patient Number:
 1

 Patient Informed:
 U

 Date Informed:

Given:

Diagnostic Study: BONE SCAN

Radiopharmaceutical: MDP/MEDRONATE/OSTEOLITE

Radionuclide: TC-99M Activity: 10 mCi 370 MBq

Intended:

- Diagnostic Study: THYROID IMAGING
- Radiopharmaceutical: SPERT/PERT (PERTECHNETATE-TCO4

Source Number:	1							
Source/Radioactive Mat	erial: UNSEAL	ED SOURCE RADIO	PHARM Ra	Radionuclide or Voltage (kVp/MeV): TC-99M				
Manufacturer:	NR		Ad	ctivity:	0.01 Ci	0.37 GBq		
Model Number:	NA							
Serial Number:	NA							
Device/Associated Equip	oment:							
MD2								
Device Number: 1								
Device Name: SYF	RINGE		M	odel Number:	NA			
Manufacturer: NR			Se	erial Number:	NA			
References:								
Reference Number:	Entry Date:	Retraction Date:	Coder Initials	Reference Ty	/pe:			
CA-XCA733	05/19/2005		DCH	AGREEMEN	T STATE EVENT REPORT			
LTR060224	02/27/2006		DCH	AGREEMEN	T STATE LETTER			

Narrative:

The licensee reported that a patient scheduled to receive 0.93 GBq (25 mCi) of Tc-99m HDP was administered 0.96 GBq (26 mCi) of Tc-99m cardiolite. The Nuclear Medicine technologist selected the wrong syringe from the dosage cart. The radiologist and referring physician were notified. The doctor informed the patient and the diagnostic study was rescheduled for 4/28/2005. Corrective action taken by the licensee included reinstructing involved personnel.

licensee included reinstructin	ng involved personnel.	-			-
Event Date	e: 04/26/2005 Dis	covery Date:	04/26/2005	Report Date:	04/26/2005
Licensee/Reporting Party Info	ormation:				
Agreement State Regulated:		Reciprocity:	NONE		
License Number:	CA-1731-43	Name:	GOOD SAMARITA	AN HOSPITAL	
NRC Docket Number:	NA	City:	SAN JOSE		
NRC Program Code:	NA	State: CA	Zip Code: 95124		
Responsible NRC Region:	4				
Site of Event:					
Site Name: SAN JOSE					
State: CA					
Additional Involved Party:					
-	NA	Name:	NA		
	NA	City:	NA		
	NA		Zip Code: NA		
-	NA		P		
Other Information:					
NRC Reportable Event:	Ν	Abnormal C)ccurrence:	Ν	
Agreement State Reportable I		Investigatio		Y	
Atomic Energy Act Material:	Y	-	ord Complete:	Ŷ	
Consultant Hired:	N		ed by Region/State:		
Frank Transa					
Event Type: MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
Cause: INATTENTION T					
	GE SELECTED FROM DOSA	GE CART			
Corrective Actions Informatio		02 0/			
Action Number: Corrective					
MD2					
	NEL RECEIVED ADDITIONAL	TRAINING			
Patient Information:					
Patient Number: 1	Data Informadu 04/00/00				
Patient Informed: Y	Date Informed: 04/26/20	105			
Given:					
Diagnostic Study: CAR	DIAC SCAN				
Radiopharmaceutical: SES					
Radionuclide: TC-99M	Activity:	26 mCi	962 MBq		
Intended:					
Diagnostic Study: BON	IE SCAN				
Radiopharmaceutical. HTD	ROXYMETHYLENE DIPHOSF	TONATE			
% Dose Exceeds Prescribed:	: NA				
% Dose is Less Than Prescri	ibed: NA				
Effect on Patient:					
Source of Radiation:					
MDO					

MD2

Source Number:	1								
Source/Radioactive	Material:	UNSEALE	D SOURCE RADIO	PHARM	ARM Radionuclide or Voltage (kVp/MeV): TC-99M				
Manufacturer:		NR			Activity	:	0	.026 Ci	0.962 GBq
Model Number:		NA							
Serial Number:		NA							
Device/Associated E	Equipmen	t:							
MD2									
Device Number:	1								
Device Name:	SYRING	E			Model	Number:	NA		
Manufacturer:	NR				Serial I	Number:	NA		
References:									
Reference Numbe	r: Enti	ry Date:	Retraction Date:	Coder Initia	als: F	Reference Type	:		
CA-XCA730	05/1	8/2005		DCH	ŀ	AGREEMENT S	TATE EVE	NT REPORT	
LTR050519	06/0	1/2005		DCH	A	AGREEMENT S	TATE LET	ΓER	
LTR050524	06/0	1/2005		DCH	ŀ	AGREEMENT S	TATE LET	ΓER	

Last Updated: 06/01/2005

Narrative:

The licensee reported that a patient not scheduled to receive radioactive material was administered 0.42 GBq (11.4 mCi) of Tc-99m MIBI for a myocardial perfusion scan. The event occurred because the imaging technologist misunderstood the order in the patient's chart. Corrective actions taken by the licensee included counseling the technician regarding his failure to follow established procedures and providing additional training to the technologist.

providing additional training	to the technologist.		ian regarang men		
Event Da	te: 04/12/2005	Discovery Date:	04/12/2005	Report Date:	04/15/2005
Licensee/Reporting Party In Agreement State Regulated:		Reciprocity:	NONE	·	
License Number:	CA-2425-33	Name:		EDICAL CENTER	
NRC Docket Number:	NA	City:	RANCHO MIRAG		
NRC Program Code:	NA	-	Zip Code: 92270		
Responsible NRC Region:	4				
Site of Event:					
Site Name: RANCHO MIRA	GE				
State: CA					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	N Event: X	Abnormal O		N Y	
Agreement State Reportable Atomic Energy Act Material:	Y	Investigation	ord Complete:	f Y	
Consultant Hired:	N		d by Region/State:		
MD2 - MEDICAL EVENT Event Cause:					
MD2					
	OLLOW PROCEDURE OR	WRONG PROCE	DURE USED		
Old Cause: PROCEDURE N	NOT FOLLOWED				
Corrective Actions Informati	on:				
Action Number: Corrective	e Action:				
MD2					
1 PERSON	NEL RECEIVED ADDITIO	NAL TRAINING			
Patient Information:					
Patient Number: 1					
Patient Informed: U	Date Informed:				
Given:					
Diagnostic Study: MY	OCARDIAL PERFUSION				
Radiopharmaceutical: MIB			404.0 MD-		
Radionuclide: TC-99M	Activity:	11.4 mCi	421.8 MBq		
Intended:					
A therapeutic procedure/dia	gnostic study was not inter	ided.			
, , , , ,					

Source Number:	1					
Source/Radioactive Ma	aterial: UNSEA	ED SOURCE RADIO	PHARM Rad	lionuclide or Voltage (kVp/M	eV): TC-99M	
Manufacturer:	NR		Act	vity: (0.0114 Ci	0.4218 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
CA-XCA726	05/18/2005		DCH	AGREEMENT STATE EV	ENT REPORT	
LTR050511	05/18/2005		DCH	AGREEMENT STATE LE	TTER	

AGREEMENT STATE LETTER

DCH

LTR050527

06/01/2005

1	8	5

Narrative:

The licensee (dba Lake City Medical Center) reported that a patient scheduled for a parathyroid scan with Tc-99m instead received a thyroid scan with 10.43 MBq (282 uCi) of I-123. The patient had no thyroid. The patient received the wrong test, radionuclide, and image area. The patient and doctor were notified the same day. It was determined that the scheduler didn't reconcile the order with the test scheduled, the desk clerk was new and didn't know the difference, the technologist assistant didn't obtain a copy of the actual order and only had the computer generated order, and the technologist was a temporary filling in for a vacationing technologist and didn't follow proper procedures. A Florida Department of Health investigator found that the written procedures were adequate, but not followed. Corrective actions taken by the licensee included training to insure written procedures are followed.

Event Date	e:	03/30/2005	Disco	very D	ate:	03/30/2005	Report Date:	04/12/2005
Licensee/Reporting Party Info	orma	tion:						
Agreement State Regulated:	YS		R	ecipro	city:	NONE		
License Number:	FL-1	193-2	Ν	lame:		NOTAMI HOSPITA	LS OF FLORIDA,	INC.
NRC Docket Number:	NA		C	ity:		LAKE CITY		
NRC Program Code:	NA		S	tate:	FL	Zip Code: 32055		
Responsible NRC Region:	1							
Site of Event:								
Site Name: LAKE CITY								
State: FL								
Additional Involved Party:								
License Number:	NA		N	lame:		NA		
NRC Docket Number:	NA		C	ity:		NA		
NRC Program Code:	NA		S	tate:	NA	Zip Code: NA		
Responsible NRC Region:	NA							
Other Information:								
NRC Reportable Event:		Ν	А	bnorm	al Oo	ccurrence:	Ν	
Agreement State Reportable	Even	t: Y	Ir	nvestig	ation	11	Y	
Atomic Energy Act Material:		Y	N	IMED F	Reco	rd Complete:	Y	
Consultant Hired:		Ν	E	vent C	lose	d by Region/State:	Y	

MD2 - MEDICAL EVENT

Event Cause: MD2 Cause: FAILURE TO FOLLOW PROCEDURE OR WRONG PROCEDURE USED Old Cause: PROCEDURE NOT FOLLOWED Corrective Actions Information: Action Number: Corrective Action:

MD2

1 PERSONNEL RECEIVED ADDITIONAL TRAINING

Patient Information:

Defie of New Arrow 4						
Patient Number: 1 Patient Informed: Y	Data Inform	ed: 03/30/200	5			
Fallent morned.	Date morne	eu. 03/30/200	5			
Given:						
Diagnostic Study:	THYROID IMAGING					
Radiopharmaceutical:	SODIUM IODIDE					
Radionuclide: I-123	Activit	y: 0.00028	82 mCi 0.010	0434 MBq		
Intended:						
Diagnostic Study:	PARATHYROID					
Radiopharmaceutical:	NR					
% Dose Exceeds Pres	cribed: NA					
% Dose is Less Than F	Prescribed: NA					
Effect on Patient:						
Source of Radiation:						
/ID2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEALED SO	URCE RADIO	PHARM Rad	lionuclide or Voltage (kV	p/MeV): I-123	
Manufacturer:	NR		Acti	vity:	0.000282 Ci	0.010434 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date: Retra	ction Date:	Coder Initials:	Reference Type:		
FL05-060	05/11/2005		DCH	AGREEMENT STATE	EVENT REPORT	
FL05-060A	08/04/2005		DCH	AGREEMENT STATE	EVENT REPORT	

Narrative:

The licensee reported that a patient, not scheduled to receive any radiopharmaceutical, was administered 18.5 MBq (0.5 mCi) of Tc-99m DTPA for a lung scan. The technologist failed to check the patient's chart prior to administration. Corrective actions taken by the licensee included reinstructing personnel.

included reinstructing perso	nnel.							
Event Dat	te: 01/26/2005	Discovery Date:	01/26/2005	Report Date:	03/22/2005			
Licensee/Reporting Party Information: Agreement State Regulated: YS License Number: CA-3834-15 NRC Docket Number: NA NRC Program Code: NA State: CA Zip Code: 93303								
NRC Program Code: Responsible NRC Region:	NA 4	State: CA	ZIP Code: 93303					
Site Name: BAKERSFIELD State: CA	-							
Additional Involved Party:								
License Number: NRC Docket Number:	NA NA	Name: City:	NA NA					
NRC Program Code: Responsible NRC Region:	NA NA	State: NA	Zip Code: NA					
Other Information:								
NRC Reportable Event:	Ν	Abnormal C	Occurrence:	Ν				
Agreement State Reportable		Investigatio		Y				
Atomic Energy Act Material: Consultant Hired:	Y N		ord Complete: ed by Region/State:	Y				
	IN	Event Close	ed by Region/State.	T				
Event Type: MD2 - MEDICAL EVENT Event Cause:								
MD2								
Cause: FAILURE TO FO Old Cause: PROCEDURE N	DLLOW PROCEDURE OR NOT FOLLOWED	WRONG PROCE	DURE USED					
Corrective Actions Informati	on:							
Action Number: Corrective	e Action:							
MD2								
1 PERSONI	NEL RECEIVED ADDITIO	NAL TRAINING						
Patient Information: Patient Number: 1								

Patient Informed: U Date Informed:

Given:

Diagnostic Study: LUNG PERFUSION

Radiopharmac	eutical:	DTPA	(DIETHYLTRIAMINE-F	PENTAACE	
Radionuclide:	TC-991	Λ	Activity:	0.5 mCi	18.5 MBq

Intended:

A therapeutic procedure/diagnostic study was not intended.

Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rac	lionuclide or Voltage (kVp	o/MeV): TC-99N	1
Manufacturer:	NR		Acti	vity:	0.0005 Ci	0.0185 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
CA-XCA715	04/20/2005		DCH	AGREEMENT STATE	EVENT REPORT	
LTR060203	02/06/2006		DCH	AGREEMENT STATE	LETTER	

Narrative:

The licensee reported that a patient prescribed to receive 1 GBq (27 mCi) of Tc-99m myoview instead received 0.93 GBq (25 mCi) of Tc-99m MDP. The hot laboratory technologist selected the wrong syringe. Corrective actions taken by the licensee included implementing a new procedure for radiopharmaceutical labeling and handling, and reinstructing personnel.

new procedure for radiopha	armaceutical labeling and hance	lling, and reinstructing	personnel.	by the licensee	e included implementing a
Event Da	ate: 02/28/2005 Di	scovery Date: 03/0	7/2005 Re	port Date:	03/15/2005
Licensee/Reporting Party In	formation:				
Agreement State Regulated		Reciprocity: NONE			
License Number:	CA-0670-37	Name: GROS	SMONT HOSPIT	AL	
NRC Docket Number:	NA	City: LA ME	SA		
NRC Program Code:	NA	State: CA Zip Co	de: 91942		
Responsible NRC Region:	4				
Site of Event:					
Site Name: LA MESA					
State: CA					
Additional Involved Party:					
License Number:	NA	Name: NA			
NRC Docket Number:	NA	City: NA			
NRC Program Code:	NA	State: NA Zip Co	de: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal Occurrer	ce: N		
Agreement State Reportable	e Event: Y	Investigation:	Y		
Atomic Energy Act Material:		NMED Record Con	plete: Y		
Consultant Hired:	Ν	Event Closed by Re	gion/State: Y		
Event Type:					
MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
Cause: INATTENTION	TO DETAIL				
Old Cause: WRONG SYRII	NGE SELECTED FROM DOS/	AGE CART			
Corrective Actions Informat	ion:				
Action Number: Correctiv	e Action:				
MD2					
1 PROCED	OURE MODIFIED				
2 PERSON	INEL RECEIVED ADDITIONAL	L TRAINING			
Patient Information:					
Patient Number: 1					
Patient Informed: U	Date Informed:				
A ¹					
Given:					
Diagnostic Study: BO	NE SCAN				
Padiopharmacoutical: MD	P/MEDRONATE/OSTEOLITE				
Radionuclide: TC-99M	Activity:		925 MBg		
	Activity.	23 110			
Intended:					
	RDIAC SCAN				
3 , - ,					

Radiopharmaceutical: MYOVIEW

% Dose Exceeds Prescribed:NA% Dose is Less Than Prescribed:NAEffect on Patient:Source of Radiation:

MD2

Source Number: 1					
Source/Radioactive Material:	UNSEALED SOURCE RADIO	PHARM Radion	uclide or Voltage (kVp/Me	eV): TC-99M	
Manufacturer:	NR	Activity	:	0.025 Ci 0	.925 GBq
Model Number:	NA				
Serial Number:	NA				
Device/Associated Equipmen	nt:				
MD2					
Device Number: 1					
Device Name: SYRING	iΕ	Model I	Number: NA		
Manufacturer: NR		Serial N	lumber: NA		
References:					
Reference Number: Ent	ry Date: Retraction Date:	Coder Initials: F	Reference Type:		
CA-XCA703 04/1	19/2005	DCH A	GREEMENT STATE EV	ENT REPORT	
LTR050622 06/2	23/2005	DCH A	GREEMENT STATE LE	ITER	

Narrative:

The licensee reported that two patients were injected with Tc-99m pertechnetate instead of the intended doses of Tc-99m Cardiolite. Following the administrations, planar images showed the classical Tc-99m pertechnetate distribution. The radiopharmacy (Cardinal Health) was notified and determined that there was inadequate binding to the sestamibi in the kit vials (the tag was al low as 76.5%). The radiopharmacy will determine if other customers experienced a tagging problem.

radiopharmacy will determine if	other customers experience	ced a tagging p	problem.		
Event Date:	03/09/2005 Dis	scovery Date:	03/09/2005	Report Date:	03/14/2005
Licensee/Reporting Party Inform					
Agreement State Regulated: YS		Reciprocity:	NONE		
License Number: CA	-0059-19	Name:	PROVIDENCE SA	INT JOSEPH MED	ICAL CENTER
NRC Docket Number: NA		City:	BURBANK		
NRC Program Code: NA		State: CA	Zip Code: 91505		
Responsible NRC Region: 4					
Site of Event:					
Site Name: BURBANK					
State: CA					
Additional Involved Party:					
License Number: NR		Name:	CARDINAL HEALT	ГН	
NRC Docket Number: NR		City:	NR		
NRC Program Code: NR		-	Zip Code: NR		
Responsible NRC Region: NR			P		
Other Information:					
NRC Reportable Event:	Ν	Abnormal C	aguranaa:	N	
•				N	
Agreement State Reportable Eve		Investigatio		N	
Atomic Energy Act Material: Consultant Hired:	Y		ord Complete:	Y	
Consultant Hired.	N	Event Close	ed by Region/State:	ř	
Event Type:					
MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
Cause: NOT REPORTED					
Old Cause: NOT REPORTED					
Corrective Actions Information:					
Action Number: Corrective Act	ion:				
MD2					
1 NOT REPORT	ſED				
Patient Information:					
Patient Number: 1					
Patient Informed: U	Date Informed:				
Given:					
Diagnostic Study: NR					
Radiopharmaceutical: SPERT/ Radionuclide: TC-99M		NR mCi			
Radionuciide: TC-99M	Activity:	NR MCI	NR MBq		
lute a de de					
Intended:	0.0041				
Diagnostic Study: CARDIA	AC SCAN				
Radiopharmaceutical: SESTAM					
% Dose Exceeds Prescribed:	NA				
% Dose is Less Than Prescribed	I: NA				
Effect on Patient:					

Patient Number: 2			
Patient Informed: U	Date Informed:		
Given:			
Diagnostic Study:	NR		
Radiopharmaceutical:	SPERT/PERT (PERTECHNETATE-TCO4		
Radionuclide: TC-99	9M Activity: NR mCi NR MBq		
Intended:			
Diagnostic Study:	CARDIAC SCAN		
Radiopharmaceutical:	: SESTAMIBI/CARDIOLITE		
% Dose Exceeds Pres	scribed: NA		
% Dose is Less Than F	Prescribed: NA		
Effect on Patient:			
Source of Radiation:			
MD2			
Source Number:	1		
Source/Radioactive Ma	Aterial: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (I	kVp/MeV): TC-99M	
Manufacturer:	CARDINAL HEALTH Activity:	NR Ci	NR GBq
Model Number:	NA		
Serial Number:	NA		
Source Number:	2		
Source/Radioactive Ma	Aterial: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): TC-99M	
Manufacturer:	CARDINAL HEALTH Activity:	NR Ci	NR GBq
Model Number:	NA		
Serial Number:	NA		
References:			
Reference Number:	Entry Date: Retraction Date: Coder Initials: Reference Type:		
CA-XCA708		TE EVENT REPORT	
LTR061207	12/12/2006 DCH AGREEMENT STA	IE LETTER	

Narrative:

The licensee reported that a patient was administered 910.2 MBq (24.6 mCi) of Tc-99m MDP for a bone scan on 3/24/2005 when no procedure was scheduled. The patient had received a bone scan on 2/16/2005 and was questioned by the technologist as to why she was having another scan so soon. The patient checked with the office and was told that there was a new order dated 3/17/2005. When the physician's office opened that morning, the licensee asked for verification of the order, which the physician denied.

physician's office opened the	hat morning, the licensee asked	d for verification of the order, wh	nich the physician de	nied.
Event Da	ate: 03/24/2005 Di	scovery Date: 03/24/2005	Report Date:	04/01/2005
Licensee/Reporting Party In Agreement State Regulated License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:		Reciprocity: NONE Name: RADIOLOGY DI City: TEMPLETON State: CA Zip Code: 9346	IAGNOSTIC CENTEI 5	R
Site of Event: Site Name: TEMPLETON State: CA				
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	Name: NA City: NA State: NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:		Abnormal Occurrence: Investigation: NMED Record Complete: Event Closed by Region/Stat	N N Y te: Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: FAILURE TO F Old Cause: PROCEDURE Corrective Actions Informat Action Number: Corrective MD2 1 NOT REF	ion: e Action:	RONG PROCEDURE USED		
Patient Information: Patient Number: 1 Patient Informed: Y	Date Informed: 03/24/2	2005		
Given: Diagnostic Study: BO	NE SCAN			
Radiopharmaceutical: MD Radionuclide: TC-99M	P/MEDRONATE/OSTEOLITE Activity:	24.6 mCi 910.2 MBq		
Intended: A therapeutic procedure/dia	ignostic study was not intended	1.		

Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM Rac	lionuclide or Voltage (kVp	o/MeV): TC-99N	1
Manufacturer:	NR		Acti	vity:	0.0246 Ci	0.9102 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
CA-XCA706	04/18/2005		RLS	AGREEMENT STATE	EVENT REPORT	-
LTR050920	09/21/2005		DCH	AGREEMENT STATE	LETTER	

Effect on Patient:

Narrative:

The licensee reported that a patient (66 year-old-female) received 1.11 GBq (30 mCi) of Tc-99m instead of the prescribed dose of 0.11 GBq (3 mCi) of Tl-201. The resident physician reviewed the prescribing physician's order for administration of a brain scan diagnostic test to image a tumor and instructed the technician to perform a standard brain scan, which images blood flow. The technician administered the Tc-99m as instructed rather than the Tl-201 prescr bed. The RSO noted that the test performed would result in a total dose of 0.322 cGy (rad) and a urinary bladder wall dose of 8.1 cGy (rad). The error was identified by the Director of Nuclear Medicine during review. The patient has not been informed and will be rescheduled for the appropriate diagnostic test.

Event Dat	e: 04	4/06/2005	Discovery Date:	04/06/2005	Report Date:	04/06/2005
Licensee/Reporting Party Inf Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:)34-26 296	Reciprocity: Name: City: State: VA	NONE UNIVERSITY OF V CHARLOTTESVIL Zip Code: 22903		
Site of Event: Site Name: CHARLOTTESV State: VA	/ILLE					
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA NA		Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:	Event:	N N Y N			N N Y N	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: HUMAN ERROF Old Cause: WRONG DIAGN Corrective Actions Informatic Action Number: Corrective MD2 1 NOT REP	IOSTIC on: Action:		APY REQUESTE	D		
Patient Information: Patient Number: 1 Patient Informed: N	C	Date Informed:				
Given: Diagnostic Study: BRA	IN SCA	AN				
Radiopharmaceutical: NR Radionuclide: TC-99M		Activity:	30 mCi	1110 MBq		
Intended: Diagnostic Study: BRA Radiopharmaceutical: NR	IN SCA	AN				
% Dose Exceeds Prescribed % Dose is Less Than Prescr		NA NA				

Source of Radiation: MD2						
Source Number: 1 Source/Radioactive Mate			PHARM Rac	lionuclide or Voltage (kVp/M	eV) [.] TC-99M	
Manufacturer: Model Number: Serial Number:	NR NA NA			vity:	0.03 Ci	1.11 GBq
	Entry Date: 04/07/2005	Retraction Date:	Coder Initials: DCH	Reference Type: EVENT NOTIFICATION		

Narrative:

The licensee reported that a patient scheduled for a prostate implant received 83 I-125 seeds, each containing an activity of 11.47 MBq (0.31 mCi), and 15 Pd-103 seeds, each containing an activity of 44.4 MBq (1.2 mCi). The patient was prescribed 98 I-125 seeds. The patient received 98% of the planned dose. The holders for the I-125 seeds and the Pd-103 seeds are similar in shape and size. The Ohio Bureau of Radiation Protection investigated the event on 3/21/2005. Results revealed that two patients were scheduled to receive permanent seed implants for prostate cancer. The sealed source containers for both patients were taken to the operating room. At some point during the procedure, one cartridge containing 15 Pd-103 seeds was implanted into the patient who was to receive I-125 seeds. The patient and referring physician were notified of the event on 3/11/2005. The licensee has instituted a new procedure where only one sealed source container will be taken into the operating room. The staff has received training on the new procedure. The Ohio Bureau of Radiation Protection will periodically inspect the licensee to insure that the corrective action is implemented and is adequate.

Event Dat	e: 03	8/11/2005	Discovery Date	e:	03/11/2005	Report Date:	03/16/2005
Licensee/Reporting Party Inf	ormatio	on:					
Agreement State Regulated:	YS		Reciprocit	ty: N	IONE		
License Number:	OH-02	120850007	Name:	Ν	ARIETTA MEMC	RIAL HOSPITAL	
NRC Docket Number:	NA		City:	Ν	/IARIETTA		
NRC Program Code:	NA		State: OF	ΗZ	Zip Code: 45750		
Responsible NRC Region:	3						
Site of Event:							
Site Name: MARIETTA							
State: OH							
Additional Involved Party:							
License Number:	NA		Name:	١	١A		
NRC Docket Number:	NA		City:	١	A		
NRC Program Code:	NA		State: NA	A Z	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abnormal	Oc	currence:	Ν	
Agreement State Reportable	Event:	Y	Investigati	ion:		Y	
Atomic Energy Act Material:		Y	NMED Re	ecor	d Complete:	Y	
Consultant Hired:		Ν	Event Close	sed	by Region/State:	Y	

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION TO DETAIL Old Cause: INATTENTION TO DETAIL

Corrective Actions Information:

Action Number: Corrective Action:

MD2

- 1 PROCEDURE MODIFIED
- 2 PERSONNEL RECEIVED ADDITIONAL TRAINING
- 3 IMPROVE RADIOACTIVE MATERIAL LABELING AND HANDLING

Patient Information:

Patient Number: 1 Patient Informed: Y	Date	Informed: 03/11/	/2005					
Given:								
Therapeutic Procedure	BRACHY. MAN	IUAL IMPLANT						
Organ:	PROSTATE							
Radiopharmaceutical:	NA							
Radionuclide: PD-103		Activity:	18 mCi	(666 MBq	Dose:	27000 rad	270 Gy
Intended:								
A therapeutic procedure	e/diagnostic stud	y was not intende	20.					
% Dose Exceeds Preso	ribed: NA							
% Dose is Less Than P	rescribed: 2							
Effect on Patient:								
Patient Number: 1A		lafama di 00/44	0005					
Patient Informed: Y	Date	Informed: 03/11	2005					
Given:								
Therapeutic Procedure		IUAL IMPLANT						
Organ:	PROSTATE							
Radiopharmaceutical:	NA		25 72 mCi	050		Desei	ND rod	
Radionuclide: I-125		Activity:	25.73 mCi	952	.01 MBq	Dose:	NR rad	NR Gy
Intended:								
Therapeutic Procedure	: BRACHY, MAN	IUAL IMPLANT						
Organ:	PROSTATE							
Radiopharmaceutical:	NA							
Radionuclide: I-125		Activity:	30.38 mCi	1124	.06 MBq	Dose:	NR rad	NR Gy
% Dose Exceeds Preso	ribed: NA							
% Dose is Less Than P	rescribed: 2							
Effect on Patient:								
Source of Radiation:								
MD2								
Source Number:	1							
Source/Radioactive Ma			HYTHERAPY			Voltage (k	/p/MeV): PD-103	0.000.00
Manufacturer:		DUSTRIES		Activ	ity:		0.018 Ci	0.666 GBq
Model Number: Serial Number:	2335 AGGREO							
Source Number:	2				Kala '			
Source/Radioactive Ma Manufacturer:		DUSTRIES	HTTHERAPT			voltage (K	/p/MeV): I-125 0.02573 Ci	0.05201 CBa
Model Number:	2301	DUSTRIES		Activ	ity.		0.02373 61	0.95201 GBq
Serial Number:	AGGREO	GATE						
References:								
Reference Number:	Entry Date:	Retraction Da	te: Coder Init	ials:	Reference	e Type:		
EN41507	03/24/2005		DCH				ON REPORTED FR	OM AN
					AGREEM	ENT STAT	E	
OH050012	03/28/2005		DCH				E EVENT REPORT	
OH050012A	04/14/2005		DCH		AGREEM	ENT STAT	E EVENT REPORT	

Narrative:

The licensee reported that a patient was administered 1 GBq (27 mCi) of Tc-99m myoview for a cardiac scan instead of the prescribed 1 GBq (27 mCi) of Tc-99m MDP for a bone scan. The event occurred because the imaging technologist selected the wrong syringe.

Event Da	te: 0	1/26/2005	Disco	overy D	ate:	01/26/2005	Report Date:	02/10/2005
Licensee/Reporting Party In	formati	on:						
Agreement State Regulated	: YS		I	Recipro	city:	NONE		
License Number:	CA-06	370-37	I	Name:		SHARP GROSSM	ONT HOSPITAL	
NRC Docket Number:	NA		(City:		LA MESA		
NRC Program Code:	NA		\$	State:	CA	Zip Code: 91942		
Responsible NRC Region:	4							
Site of Event:								
Site Name: LA MESA								
State: CA								
Additional Involved Party:								
License Number:	NA		I	Name:		NA		
NRC Docket Number:	NA		(City:		NA		
NRC Program Code:	NA		\$	State:	NA	Zip Code: NA		
Responsible NRC Region:	NA							
Other Information:								
NRC Reportable Event:		Ν		Abnorm	al O	ccurrence:	Ν	
Agreement State Reportable	e Event:	Y	I	Investig	ation	11	Y	
Atomic Energy Act Material:		Y	I	NMED F	Reco	rd Complete:	Y	
Consultant Hired:		Ν	I	Event C	lose	d by Region/State:	Υ	
Event Type:								
MD2 - MEDICAL EVENT								
Event Cause:								

Event Cause: MD2 Cause: INATTENTION TO DETAIL Old Cause: WRONG SYRINGE SELECTED FROM DOSAGE CART

Corrective Actions Information:

Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Information:

Patient Number:1Patient Informed:UDate Informed:

Given:

Diagnostic Study: CARDIAC SCAN

BONE SCAN

Radiopharmaceutical: MYOVIEW

Radionuclide: TC-99M Activity: 27 mCi 999 MBq

Diagnostic Study:

Radiopharmaceutical: MDP/MED	RONATE/OSTEOLITE		
Radionuclide: TC-99M	Activity:	27 mCi	999 MBq
% Dose Exceeds Prescribed:	NA		
% Dose is Less Than Prescribed:	NA		
Effect on Patient:			
Source of Radiation:			
MD2			

Source Number: 1					
Source/Radioactive Material:	UNSEALED SOURCE RADIOF	PHARM Radior	nuclide or Voltage (kVp/M	eV): TC-99M	
Manufacturer:	NR	Activity	y:	0.027 Ci	0.999 GBq
Model Number:	NA				
Serial Number:	NA				
Device/Associated Equipmen	ıt:				
MD2					
Device Number: 1					
Device Name: SYRING	E	Model	Number: NA		
Manufacturer: NR		Serial	Number: NA		
References:					
Reference Number: Ent	ry Date: Retraction Date:	Coder Initials:	Reference Type:		
CA-XCA691 03/2	22/2005	DCH	AGREEMENT STATE EV	ENT REPORT	
LTR050622 06/2	23/2005	DCH	AGREEMENT STATE LE	TTER	

Effect on Patient: Source of Radiation:

Narrative:

The licensee reported that a patient was administered 1 GBq (27 mCi) of Tc-99m MDP for a bone scan instead of the prescribed 185 MBq (5 mCi) of I-131 for a total body scan. The event was caused by an error in transcription of the order by a student technologist. The patient and physician were notified of the error and the correct radiopharmaceutical was later administered. The senior technologist was reprimanded by the Radiology Department Head for not properly supervising the procedure. The State of Louisiana Department of Environmental Quality performed an investigation of the incident.

performed an investigation of the	he incident.				-
Event Date:	01/26/2005 Di	scovery Date:	01/26/2005	Report Date:	03/03/2005
Licensee/Reporting Party Inform Agreement State Regulated: YS License Number: LA NRC Docket Number: NA NRC Program Code: NA Responsible NRC Region: 4 Site of Event: Site Name: NEW ORLEANS State: LA	S A-0004-L01 A	City: N	ONE ULANE UNIVERS EW ORLEANS ip Code: 70112	SITY	
Additional Involved Party:					
License Number: N/ NRC Docket Number: N/ NRC Program Code: N/ Responsible NRC Region: N/	A A		A A ip Code: NA		
Other Information:					
NRC Reportable Event: Agreement State Reportable Ev Atomic Energy Act Material: Consultant Hired:	N vent: Y Y N	Abnormal Occ Investigation: NMED Record Event Closed		N Y Y Y	
MD2 Cause: INATTENTION TO Old Cause: TECHNOLOGIST S Corrective Actions Information: Action Number: Corrective Act MD2 1 PERSONNEI	SELECTED WRONG RAD	IOPHARMACEU	TICAL FOR UNIT	DOSE	
Patient Information: Patient Number: 1 Patient Informed: Y Given: Diagnostic Study: BONE	Date Informed: 01/26/2 SCAN	2005			
Radiopharmaceutical: MDP/M Radionuclide: TC-99M	IEDRONATE/OSTEOLITE Activity:	27 mCi	999 MBq		
Intended: Diagnostic Study: WHOL	E BODY I-131/THYROID				
Radiopharmaceutical: SODIU Radionuclide: I-131	M IODIDE Activity:	5 mCi	185 MBq		
% Dose Exceeds Prescribed: % Dose is Less Than Prescribe	NA ed: NA				

MD2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RADIO	PHARM R	adionuclide or Voltag	e (kVp/MeV): TC-99M	
Manufacturer:	NR		A	ctivity:	0.027 Ci	0.999 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials	: Reference Type):	
EN41478	03/15/2005		DCH	EVENT NOTIFIC AGREEMENT S	CATION REPORTED FR	OM AN
LA050003	01/31/2006		DCH	AGREEMENT S	TATE EVENT REPORT	

Effect on Patient: Source of Radiation:

MD2

Narrative:

The licensee reported that a patient was prescr bed 185 MBq (5 mCi) of Tc-99m MAA for a lung scan, but was administered 185 MBq (5 mCi) of Tc-99m choletec. The cause of the event was determined to be that the pharmacy had mislabeled the syringe. Corrective actions taken by the pharmacy included revising vial shields and labels.

taken by the pharmacy include	d revising vial shields and	labels.			
Event Date:	01/10/2005 D	iscovery Date:	01/10/2005	Report Date:	01/24/2005
Licensee/Reporting Party Inform Agreement State Regulated: YS License Number: C/ NRC Docket Number: N/ NRC Program Code: N/ Responsible NRC Region: 4 Site of Event: Site Name: REDDING	mation: S A-1380-45 A	Reciprocity: Name: City:			TER
State: CA					
Additional Involved Party:					
License Number: N/ NRC Docket Number: N/ NRC Program Code: N/ Responsible NRC Region: N/	A	Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event:	Ν	Abnormal C)ccurrence.	N	
Agreement State Reportable Ev		Investigatio		Y	
Atomic Energy Act Material:	Y	-		Y	
Consultant Hired:	Ν	Event Close	ed by Region/State:	Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION TO Old Cause: SYRINGE MISLAB Corrective Actions Information: Action Number: Corrective Act MD2 1 PROCEDUR	ELED :				
Patient Information: Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: NR					
Radiopharmaceutical: MEBR Radionuclide: TC-99M	OFENIN/CHOLETECH Activity:	5 mCi	185 MBq		
Intended: Diagnostic Study: LUNG	PERFUSION				
Radiopharmaceutical: MAA (N Radionuclide: TC-99M	MACROAGGREGATED AI Activity:	LBUMIN) 5 mCi	185 MBq		
% Dose Exceeds Prescribed: % Dose is Less Than Prescribe	NA ed: NA				

Source Number:	1							
Source/Radioactive	Material:	UNSEALED S	OURCE RADIO	PHARM	Radionucli	de or Voltage (k	Vp/MeV): TC	-99M
Manufacturer:		NR			Activity:		0.005 Ci	0.185 GBq
Model Number:		NA						
Serial Number:		NA						
Device/Associated E	quipmen	t:						
MD2								
Device Number:	1							
Device Name:	SYRING	Ξ			Model Num	nber: I	NA	
Manufacturer:	NR				Serial Num	iber:	NA	
References:								
Reference Number CA-XCA679		ry Date: Ref 8/2005	raction Date:	Coder Initi a DCH		rence Type: EEMENT STAT	E EVENT REF	PORT

Narrative:

The licensee reported that a patient was prescr bed a cardiac study using Tc-99m cardiolite. The procedure was cancelled, but the Nuclear Medicine Department was not aware of the cancellation. The patient was administered 0.3 GBq (8 mCi) of Tc-99m cardiolite because the technician failed to check the patient's chart prior to administration. Corrective actions taken by the licensee included implementing a new procedure and reinstructing personnel.

procedure and reinstructing	personnel.				
Event Da	te: 01/18/2005 Di	scovery Date	01/18/2005	Report Date:	01/19/2005
Licensee/Reporting Party In	formation:				
Agreement State Regulated:		Reciprocity	NONE		
License Number:	CA-1021-30	Name:	WEST ANAHEIM I	MEDICAL CENTER	R
NRC Docket Number:	NA	City:	ANAHEIM		
NRC Program Code:	NA	State: CA	Zip Code: 92804		
Responsible NRC Region:	4				
Site of Event:					
Site Name: ANAHEIM					
State: CA					
Additional Involved Party:					
License Number:	NA	Name:	NA		
NRC Docket Number:	NA	City:	NA		
NRC Program Code:	NA	State: NA	Zip Code: NA		
Responsible NRC Region:	NA				
Other Information:					
NRC Reportable Event:	Ν	Abnormal C	Occurrence:	Ν	
Agreement State Reportable	e Event: Y	Investigatio	n:	Y	
Atomic Energy Act Material:	Y		ord Complete:	Y	
Consultant Hired:	Ν	Event Close	ed by Region/State:	Y	
Event Type:					
MD2 - MEDICAL EVENT					
Event Cause:					
MD2					
	OLLOW PROCEDURE OR WE	RONG PROCE	EDURE USED		
Old Cause: PROCEDURE N					
Corrective Actions Informati					
Action Number: Corrective	e Action:				
MD2					
	OCEDURE WRITTEN NEL RECEIVED ADDITIONAL				
Z FLRJON					
Patient Information:					
Patient Number: 1					
Patient Informed: U	Date Informed:				
Given:					
Diagnostic Study: CAF	RDIAC SCAN				
Radiopharmaceutical: SES	STAMIBI/CARDIOLITE				

Radionuclide: TC-99M Activity: 8 mCi 296 MBq

Intended:

A therapeutic procedure/diagnostic study was not intended.

MD2						
Source Number:	1					
Source/Radioactive Ma	terial: UNSEAL	ED SOURCE RADIO	PHARM Rac	lionuclide or Voltage (k	Vp/MeV): TC-99M	
Manufacturer:	NR		Acti	vity:	0.008 Ci	0.296 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:		
CA-XCA672	02/23/2005		DCH	AGREEMENT STAT	E EVENT REPORT	

Narrative:

The licensee reported that a patient received a dose to an incorrect site. A nuclear medicine technician attempted to inject 1.21 GBq (32.7 mCi) of Tc-99m into an implanted single lumen port near the left breast of a female patient for a red blood cell study. After injecting 0.78 GBq (21.1 mCi), the technician noticed resistance and could not deliver the rest of the dose. A scan of the patient indicated that the material was not metabolizing. The nuclear medicine physician determined that the dose had been delivered to a 15 to 30 cubic centimeter volume of tissue around the port. The committed absorbed dose to this tissue volume was estimated to be on the order of 52.7 to 83.2 cGy (rad). The patient was notified and no deleterious effects are expected. The licensee has not determined if the internal line was crimped by the patient or if the port failed.

Event Dat	:e: ()2/04/2005	Discovery	Date	: 02/04/2005	Report Date:	02/04/2005
Licensee/Reporting Party Inf	ormat	ion:					
Agreement State Regulated:	NO		Recip	orocity	NONE		
License Number:	06-13	8022-02	Nam	e:	UNIVERSITY OF (CONNECTICUT HE	ALTH CENTER
NRC Docket Number:	0300	1295	City:		FARMINGTON		
NRC Program Code:	02110	D	State	: CT	Zip Code: 06030		
Responsible NRC Region:	1						
Site of Event:							
Site Name: FARMINGTON							
State: CT							
Additional Involved Party:							
License Number:	NA		Nam	e:	NA		
NRC Docket Number:	NA		City:		NA		
NRC Program Code:	NA		State	: NA	Zip Code: NA		
Responsible NRC Region:	NA						
Other Information:							
NRC Reportable Event:		Ν	Abno	rmal (Occurrence:	Ν	
Agreement State Reportable	Event	: N	Inves	tigatic	n:	Ν	
Atomic Energy Act Material:		Y	NME	D Rec	ord Complete:	Y	
Consultant Hired:		Ν	Even	t Clos	ed by Region/State:	Ν	
Event Type:							

Event Type:

MD2 - MEDICAL EVENT Event Cause: MD2 Cause: NOT REPORTED Old Cause: NOT REPORTED Corrective Actions Information: Action Number: Corrective Action: MD2

1 NOT REPORTED

Patient Information:

Patient Number: 1						
Patient Informed: Y	Date	Informed:				
Given:						
Diagnostic Study:	RBC VOLUME	MEASUREMENT				
Radiopharmaceutical:	NR					
Radionuclide: TC-99	Μ	Activity:	21.1 mCi	780.7 MBq		
Intended:						
Diagnostic Study:	RBC VOLUME	MEASUREMENT				
Radiopharmaceutical:	NR					
% Dose Exceeds Pres	cribed: NA					
% Dose is Less Than F	Prescribed: NA	L.				
Effect on Patient:						
Source of Radiation:						
MD2						
Source Number:	1					
Source/Radioactive Ma	aterial: UNSEAL	ED SOURCE RAD	IOPHARM F	adionuclide or Voltag	ge (kVp/MeV): TC-99M	
Manufacturer:	NR		A	ctivity:	0.0211 Ci	0.7807 GBq
Model Number:	NA					
Serial Number:	NA					
References:						
Reference Number:	Entry Date:	Retraction Date	: Coder Initials	: Reference Type) :	
EN41375	02/07/2005	02/09/2005	RLS	EVENT NOTIFIC	CATION	
EN41375A	02/10/2005	02/09/2005	RLS	EVENT NOTIFIC	CATION	

Narrative:

The licensee reported that a patient was administered 814 MBq (22 mCi) of Tc-99m Myoview instead of the prescribed dose of 740 MBq (20 mCi) of Tc-99m MDP for a bone scan. The imaging technologist selected the wrong syringe. Corrective actions included reinstructing personnel.

personnel.	gg				g
Event Dat	e: 01/12/2005	Discovery Date:	01/12/2005	Report Date:	01/12/2005
Event Dat Licensee/Reporting Party Info Agreement State Regulated: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region: Site of Event: Site Name: LAGUNA BEACH State: CA Additional Involved Party:	ormation: YS CA-0920-30 NA NA 4	Reciprocity: Name: City:	NONE	MEDICAL CENTER	01/12/2005
License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:	N Event: Y Y N			N Y Y : Y	
Event Type: MD2 - MEDICAL EVENT Event Cause: MD2 Cause: INATTENTION T Old Cause: WRONG SYRIN Corrective Actions Information Action Number: Corrective MD2 1 PERSONN	GE SELECTED FROM I				
Patient Information: Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: CAR	RDIAC SCAN				
Radiopharmaceutical: MYC Radionuclide: TC-99M	OVIEW Activity:	22 mCi	814 MBq		
Intended: Diagnostic Study: BON	IE SCAN				
Radiopharmaceutical: MDF	P/MEDRONATE/OSTEO	LITE			
% Dose Exceeds Prescribed % Dose is Less Than Prescri Effect on Patient:					

Source of Radiation:

Source Number:	1							
Source/Radioactive	Material:	UNSEALED SO	OURCE RADIO	PHARM	Radionuclic	le or Voltage (kVp	p/MeV): TC-99N	l
Manufacturer:		NR			Activity:		0.022 Ci	0.814 GBq
Model Number:		NA						
Serial Number:		NA						
Device/Associated E	quipmen	t:						
MD2								
Device Number:	1							
Device Name:	SYRING	Ξ			Model Num	ber: N/	Ą	
Manufacturer:	NR				Serial Numl	ber: N/	A	
References:								
Reference Numbe CA-XCA669		y Date: Ret 7/2005	raction Date:	Coder Initi RLS		r ence Type: EEMENT STATE	EVENT REPORT	

Narrative:

The licensee reported that a patient was administered 444 MBq (12 mCi) of Tc-99m Myoview instead of the prescribed dose of 740 MBq (20 mCi) of Tc-99m MDP for a bone scan. The imaging technologist selected the wrong syringe and did not verify the dose. Corrective actions included implementing new procedures, reinstructing personnel, and reprimanding the technologist.

Event Dete: 01/06/2005 Report place: 01/06/2005 Agreement State Regulate: YS Reciprocity: NONE License Number: C::::::::::::::::::::::::::::::::::::	included implementing new procedures, reinstructing	g personnel, and reprimanding the tech	nologist.	The dose. Corrective actions
Agreement State Regulated: YS Reciprodity: NONE License Number: CA-0450-37 Name: SCRIPPS CLINIC TORREY PINES NRC Docket Number: NA City: LA JOLLA NRC Program Code: NA State: CA Responsible NRC Region: A Site of Event: State: CA State: CA Amme: NA NRC Docket Number: NA Name: NA NRC Docket Number: NA State: NA NRC Docket Number: NA Abnormal Occurrence: N Agreement State Reportable Event: N MAED Record Complete: Y Routlant Hired: N	Event Date: 01/06/2005	Discovery Date: 01/06/2005	Report Date:	01/06/2005
License Number: CA-0450-37 Name: SCRIPPS CLINIC TORREY PINES NRC Program Code: NA Site : City: LA JOLLA Site of Event: Site : Site : City: LA JOLLA Site of Event: Site : NA Site : Caty: Site : License Number: NA Name: NA Name: Name: Name: Additional Involved Party: License Number: NA Name: Name: <td>Licensee/Reporting Party Information:</td> <td></td> <td></td> <td></td>	Licensee/Reporting Party Information:			
NRC Docket Number: NA City: LA JOLLA NRC Program Code: NA State: CA Zip Code: 92037 Responsible NRC Region: 4 Site of Event: State:: CA Site of Event: State:: CA State:: CA CA Additional Involved Party: Name:: NA Leense Number:: NA Name:: NA NRC Docket Number:: NA State:: NA NRC Program Code:: NA State:: NA Responsible NRC Region:: NA State:: NA MRC Docket Number:: NA State:: NA MRC Docket Name: NA State:: NA MRC Program Code:: NA State:: NA MRC Docket Name: NA State:: NA MRC Docket State Reportable Event ' N Abnormal Occurrence:: N Adomic Energy Act Material:: Y NMED Record Complete: Y Consultant Hired:: N MD2 MD2 Cornective Actions Information: Activent Zip Code:: Activent Zip	Agreement State Regulated: YS	Reciprocity: NONE		
NRC Program Code: NA State: CA Zip Code: 92037 Responsible NRC Region: 4 State: CA Mathematic LA JOLLA State: CA Additional Involved Pary: Leanse Number: NA Name: NA Mathematic Norved Pary: Leanse Number: NA Name: NA NRC Docket Number: NA City: NA Name: NA NRC Porgram Code: NA State: NA Zip Code: NA Responsible NRC Region: NA Abnormal Occurrence: N Agreement State Reportable Event: Y Investigation: Y NRC Reportable Event: N Abnormal Occurrence: N Agreement State Reportable Event: Y NMED Record Complete: Y Consultant Nired: N Event Closed by Region/State: Y Event Close Y MD2 Cause: INATTENTION TO DETAIL Old Cause: WROR SYNINGE SELECTED FROM DOSAGE CART Correlive Actions Information: Peresconnel: Baterion Number: 1 NEW PROCEDURE WRITTEN 2 PERSo			TORREY PINES	
Responsible NRC Region: 4 Site of Event:		-		
Site of Event: Site of Event: State: Color Additional involved Pary: License Number: NRC Docket Number: NA NRC Docket Number: NA State: NRC Pogram Code: NA Responsible NRC Region: NRC Poporation Event: NRC Poporation Event: NRC Poporation Event: NRC Poporation: State: NRC Poporation: Action Number: Net Proporation: Net Proporation: Action Number: Patient Information: Patient Information: Patient Information: Patient Information: Patient Information: Patient Number: Net Poporation: Patient Information: Patient Information: <td>-</td> <td>State: CA Zip Code: 92037</td> <td></td> <td></td>	-	State: CA Zip Code: 92037		
Site Name: LA JOLLA Site: CA Additional Involved Party: License Number: NA Name:				
State: CA Additional involved Party: License Number:: NA NRC Dockt Number:: NA MRC Dockt Number:: NA State: NA Zip Code: Responsible NRC Region: NA Berner State Reportable Event: N Adornic Energy Act Material: N MCR Cocket Particle N Adornic Energy Act Material: N MCR Parenert State Reportable Event: N Adornic Energy Act Material: N MCR Parenert State Reportable Event: N Atornic Energy Act Material: N MCR Cocket Event Event N MCR Corrective Actions N MCR Cocket Event Event N Detertor N <tr< td=""><td></td><td></td><td></td><td></td></tr<>				
License Number: NA Name: NA NRC Docket Number: NA City: NA NRC Regarma Code: NA State: NA Responsible NRC Region: NA State: NA Responsible NRC Region: NA State: NA Other Information: N Abnormal Occurrence: N Agreement State Reportable Event: N Abnormal Occurrence: N Agreement State Reportable Event: Y NIMED Record Complete: Y More Trype: N Event Closed by Region/State: Y MD2 Cause: NATTENTION TO DETAIL Old Cause: NOTONE SYRINGE SELECTED FROM DOSAGE CART Cause: INATTENTION TO DETAIL Old Cause: Corrective Action: MD2 1 NEW PROCEDURE WRITTEN 2 2 PERSONNEL REPRIMANDED PERSONNEL REPRIMANDED Patient Information: Patient Informed: Patient Information: Event: Patient Information: Date Informed: Patient Information: Patient Informed: Patient Information: Cause: Patient Information: Date Informed: Patient Information: Patient Informed: Patient Informatio: Patient Inform				
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NRC Program Code: NA State: NA Zip Code: NA Responsible NRC Region: NA NA Other Information: NRC Reportable Event: N Abnormal Occurrence: N Agreement State Reportable Event: N Abnormal Occurrence: N Agreement State Reportable Event: Y Investigation: Y Agreement State Reportable Event: Y Investigation: Y Adroit Energy Act Material: Y NMED Record Complete: Y Consultant Hired: N Event Closed by Region/State: Y MD2 MEDICAL EVENT Event Closed by Region/State: Y MD2 MEDICAL EVENT Event Closed by Region/State: Y MD2 MCCause: INATTENTION TO DETAIL Old Gause: NRONG SYRINGE SELECTED FROM DOSAGE CART Cause: INATTENTION TO DETAIL Old Gause: MENOR SYRINGE SELECTED FROM DOSAGE CART Cause: INATTENTION TO DETAIL Old Gause: MENOR MD2 1 NEW PROCEDURE WRITTEN 2 A preprionent Exercitive Action: MD2 1 NEW PROCEDURE WRITTEN A preprionent Exercitive Action: Patient Information: 1 Patient Information: 1 Patient Information: 1 Patient Information: 1 Patient Informatio: 1 Bagnostic Study: CARDIAC SCAN Radiopharmaceutica: MYOVIEW Radiopharmaceutica: MYOVIEW	-	Name: NA		
Responsible NRC Region: NA Other Information: N NC Reportable Event: N Agreement State Reportable Event: Y N Nevestigation: Y Atomic Energy Act Material: Y N Event Closed by Region/State: Y Consultant Hired: N Event Closed by Region/State: Y Event Type: MD2 Event Closed by Region/State: MD2 Event Closed: MD2 Event Orgen Event: MD2 Cause: N Event Closed by Region/State: MD2 Cause: Cause: INATTENTION TO DETAIL Old Cause: WRONG SYRINGE SELECETED FROM DOSAGE CART Corrective Actions Information: Event Closed by Region/State: Action Number: Corrective Action: MD2 1 Action Number: Corrective Action: MD2 1 Action Number: Corrective Action: MD2 1 N Event Closed by Region/State: Patient Information: Event Closed by Region/State: Patient Informet: Date Informet: Patient Informet: Date Informet: Patient Informet: MOV/EW Radionuclide: TC-99M Activity: 12 mCi Hattendi Bone Scan	NRC Docket Number: NA	City: NA		
Other Information: N Abnormal Occurrence: N NRC Reportable Event: N Abnormal Occurrence: N Atomic Energy Act Material: Y NMED Record Complete: Y Atomic Energy Act Material: N Event Closed by Region/State: Y Consultant Hired: N Event Closed by Region/State: Y MD2 Cause: INATTENTION TO DETAIL Old Cause: WRONG SYRINGE SELECTED FROM DOSAGE CART Corrective Actions Information: Action Number: Corrective Actions Information: Corrective Actions Information: MD2 1 NEW PROCEDURE WRITTEN 2 PERSONNEL RECEIVED ADDITIONAL TRAINING 3 PERSONNEL RECEIVED ADDITIONAL TRAINING 3 PERSONNEL REPRIMANDED Patient Information: 1 Date Informed: E Patient Informatio: 1 Date Informed: E Patient Informatio: 1 Date Informed: E Patient Informatio: 1 Date Informed: E Biagnostic Study: CARDIAC SCAN E E Radiopharmaceutical: MYOVIEW Radiopharmaceutical: MYOV	NRC Program Code: NA	State: NA Zip Code: NA		
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Patient Number: 1 Patient Informed: U Date Informed: Given: Diagnostic Study: CARDIAC SCAN Radiopharmaceutical: MYOVIEW Radionuclide: TC-99M Activity: 12 mCi 444 MBq	Patient Information:			
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Diagnostic Study: CARDIAC SCAN Radiopharmaceutical: MYOVIEW Radionuclide: TC-99M Activity: 12 mCi 444 MBq Intended: Diagnostic Study: BONE SCAN	Given:			
Radiopharmaceutical: MYOVIEW Radionuclide: TC-99M Activity: 12 mCi 444 MBq Intended: Diagnostic Study: BONE SCAN				
Radionuclide: TC-99M Activity: 12 mCi 444 MBq Intended: Diagnostic Study: BONE SCAN Figure 10 mCi Figure 10 mCi				
Intended: Diagnostic Study: BONE SCAN	Radiopharmaceutical: MYOVIEW			
Diagnostic Study: BONE SCAN	Radionuclide: TC-99M Activity:	12 mCi 444 MBq		
Diagnostic Study: BONE SCAN	Intended			
Radiopharmaceutical: MDP/MEDRONATE/OSTEOLITE				
	Radiopharmaceutical: MDP/MEDRONATE/OSTEC	LITE		

% Dose Exceeds Prescribed:NA% Dose is Less Than Prescribed:NAEffect on Patient:VA

Source of Radiation:					
MD2					
Source Number: 1					
Source/Radioactive Material:	UNSEALED SOURCE RADIOF	PHARM Radio	onuclide or Voltage (kVp	/MeV): TC-99M	
Manufacturer:	NR	Activi	ty:	0.012 Ci	0.444 GBq
Model Number:	NA				
Serial Number:	NA				
Device/Associated Equipmen	t:				
MD2					
Device Number: 1					
Device Name: SYRINGI	E	Mode	I Number: NA	۱.	
Manufacturer: NR		Seria	Number: NA	N Contraction of the second seco	
References:					
	ry Date: Retraction Date: 27/2005	Coder Initials: RLS	Reference Type: AGREEMENT STATE	EVENT REPORT	

Narrative:

The licensee reported that a patient was administered 1.07 GBq (29 mCi) of Tc-99m pertechnetate instead of the prescribed dose of 1.07 GBq (29 mCi) of Tc-99m Cardiolite. The imaging technologist selected the wrong syringe. Corrective actions included reinstructing personnel and reprimanding the technologist.

personnel and reprimanding	g the technologist.	ogist selected i	ne wrong synnge.	Corrective actions	included reinstructing
Event Da	ite: 01/01/2005 Di	scovery Date:	01/01/2005	Report Date:	01/07/2005
Licensee/Reporting Party In	formation:				
Agreement State Regulated License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:		Reciprocity: Name: City: State: CA	NONE MERCY SAN JUAI CARMICHAEL Zip Code: 95608	N MEDICAL CENT	ER
Site of Event: Site Name: CARMICHAEL State: CA					
Additional Involved Party: License Number: NRC Docket Number: NRC Program Code: Responsible NRC Region:	NA NA NA	Name: City: State: NA	NA NA Zip Code: NA		
Other Information: NRC Reportable Event: Agreement State Reportable Atomic Energy Act Material: Consultant Hired:				N Y Y Y	
Corrective Actions InformatiAction Number:CorrectiveMD21PERSON	NGE SELECTED FROM DOSA ion:				
Patient Information: Patient Number: 1 Patient Informed: U	Date Informed:				
Given: Diagnostic Study: NR					
Radiopharmaceutical: SPI Radionuclide: TC-99M	ERT/PERT (PERTECHNETAT Activity:	E-TCO4 29 mCi	1073 MBq		
Intended: Diagnostic Study: CAI	RDIAC				
Radiopharmaceutical: SES	STAMIBI/CARDIOLITE				

Source Number: 1				
Source/Radioactive Mater	rial: UNSEALED SOURCE RADIOF	PHARM Radionuclide o	r Voltage (kVp/MeV): TC-99M	
Manufacturer:	NR	Activity:	0.029 Ci	1.073 GBq
Model Number:	NA			
Serial Number:	NA			
Device/Associated Equipm	nent:			
MD2				
Device Number: 1				
Device Name: SYRII	NGE	Model Number	: NA	
Manufacturer: NR		Serial Number:	NA	
References:				
	Entry Date: Retraction Date: 01/27/2005		ce Type: MENT STATE EVENT REPORT	